FAMILY HEALTH & WELLNESS CENTER

1500 E Cedar Ave., Ste 26, Flagstaff, Arizona 86004

PATIENT INFORMATION SHEET

Name(Last, First, Middle):		Other Names Used(Alias):	Sex: M F	Chart #:
Date of Birth:	Place of Birth(City & State):	Social Security #:	Primary Language:	Secondary Language:
Mailing Address:	City/State:	Zip Code:	Primary Phone #:	
Current Community:	Date Moved:		Secondary Phone #:	

Marital Status: __SINGLE SEPERATED __COMMON-LAW DIVORCED __MARRIED WIDOWED	Ethnicity: __NATIVE AMERICAN __CAUCASIAN __HISPANIC __OTHER:_____	Primary Tribal Enrollment: Other Tribe(s):	Degree: Degree:	Census Number: Religious Preference:
Employer Information: __EMPLOYED(FULL-TIME) DISABLED __EMPLOYED(PART-TIME) STUDENT __UNEMPLOYED CHILD UNDER 4 __RETIRED	Patient's Employer: Employer Address: Phone #: Spouse's Employer: Employer Address: Phone #:			
Preferred Contact Method: __PHONE MAIL EMAIL NONE	Internet Access: Where: __YES __NO		Email Address:	
Are you related to a NACA Employee? Please list Name & Dept. :				

PARENTAL INFORMATION for MINORS

Fathers Name:	Father's Employer:	Contact Phone #:	Place of Birth: (City/State)
Mother's Maiden Name:	Mother's Employer:	Contact Phone #:	Place of Birth: (City/State)

HEALTH INSURANCE INFORMATION

Medicare Number:	Suffix:(A,B & D):	Part A Eligibility Date:	Part B Eligibility Date:	
AHCCCS ID #:		Plan Name:		Eligibility Date:
Private Insurance Company Name:		Policy ID#:		Insurance Phone #:
Policyholder's Name:	Policyholder's Date of Birth:	Group #:		Effective Date:

EMERGENCY CONTACT AND NEXT OF KIN INFORMATION

Name of Emergency Contact:		Phone # of Emergency Contact:	Relationship to Patient:
Emergency Contact's Address:	City/State:		Zip Code:
Name of Next-of-Kin Contact		Phone # of Next-of-Kin Contact:	Relationship to Patient:

MILITARY SERVICE INFORMATION

Military Service: __Yes No	Vietnam Veteran: __Yes No	Branch:	Entry Date:	Separation Date:	Service Connected: __Yes No

* I certify that the information on this form is true and accurate, as of the date of signature.
* I agree to contact NACA if the information on this form changes in any way.
* I hereby authorize NACA to furnish information to insurance carriers concerning my illness, and I hereby irrevocably assign to NACA payments for medical services rendered.
* I understand that I am financially responsible for ALL charges whether or not covered by insurance.

Patient Signature Date

GENERAL CONSENT FOR TREATMENT

Patient/Client Name: _____ Date of Birth: _____

General Consent for Treatment

I request and authorize health care services by my provider and his/her designee(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, radiology, and laboratory procedures and medication prescription and administration.

I understand no substantial procedure will be performed without providing me an opportunity to give informed consent for that procedure, unless there is an emergency or extraordinary circumstance. Informed consent means the provider will disclose to me expected benefits and risks of a particular procedure and/or treatment. This understanding includes research and/or experimental procedures will not be performed without my knowledge and consent.

Release of Medical Information

I authorize *Native Americans for Community Action, Inc*. (NACA) to use my health information related to the services provided for the following purposes: my treatment, obtaining payment for the services provided, and for health care operations of NACA or other treating providers, as permitted under federal and state laws and regulations.

Payment

I assign and authorize payment for all services provided directly to NACA from my insurance company or third party payer, including, but not limited to, Medicare, AHCCCS, commercial health insurance, automobile no-fault insurance, and workers compensation insurance.

In consideration of the health care services provided to me, I agree to pay all charges not covered by my insurance company or any applicable health benefit including, but not limited to, deductibles, co-payments, and non-covered services.

I have read this consent form, or it has been read to me, and I understand the contents. My questions have been answered to my satisfaction.

_____ _____

Signature of Patient/Client Date

_____ _____

Signature of Parent/Guardian (if applicable) Relationship to Patient/Client

_____ _____

Signature of Witness Date

ACKNOWLEDGEMENT OF INFORMATION RECEIVED

Patient/Client Name: _____ Date of Birth: _____

I confirm I have received the following information in writing, and understand its content. I understand it is my responsibility to address any further questions I have regarding this information with my medical practitioner, case manager, nurse, therapist, and/or counselor.

_____ Initial I have read and understand the **Patient/Client Rights and Responsibilities**, including the grievance procedure and mandatory reporting requirements.

_____ Initial I have read and understand the **HIPAA Notice of Privacy Practices**, including who to contact if I suspect my protected health information has been compromised.

_____ Initial I have been offered information regarding **Advance Directives** and my options for establishing advance directives and/or a power of attorney.

_____ Initial I have received a copy of the **Fee Schedule** and understand I am responsible for payment for services received. I agree to cancel appointments at least 24 hours in advance or agree to pay a $25 cancellation fee.

_____ Initial I have read and understand NACA Family Health Center's participation in the Health Information Exchange and read the **Notice of Health Information Practices**.

_____ _____

Patient/Client signature Date

_____ _____

Parent/Guardian signature (if applicable) Date

_____ _____

Employee/Witness signature Date

Adult Health Risk Assessment

Date: _____ **Date of Birth:** _____

Name: _____ **Preferred Pronouns (optional):** _____

General Health	
Form completed by:	☐ Self ☐ Friend/Family ☐ Clinic Staff ☐ Other
How do you rate your overall health?	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
Rate your pain on a scale on 0-10, where 0 means no pain at all and 10 means the worst pain imaginable.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Do you use opioids to control your pain? (Examples: morphine, methadone, oxycodone)	☐ Yes ☐ No If yes, would you like to try other pain management alternatives? ☐ Yes ☐ No
Do you have any allergies? (Medication, Food, Animal, Other)	☐ Yes ☐ No Allergy: _____ Reaction: _____ Allergy: _____ Reaction: _____
Please list your Medications (include dose strength and frequency).	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____
How do you rate your oral health? (teeth, gums, dentures)	☐ Excellent ☐ Good ☐ Fair ☐ Poor
Your Medical History *(check if you have had any of the following conditions)*	

☐ Attention Deficit / Hyperactivity Disorder ☐ Allergies ☐ Anemia ☐ Angina ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Atrial Fibrillation ☐ Autism Spectrum Disorder ☐ Autoimmune Disease ☐ Blood Clots ☐ Cancer Cancer Type: _____ ☐ Cardiac Arrythmias	☐ COPD ☐ Coronary Artery Disease ☐ Depression ☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ High Cholesterol ☐ Statin Therapy (simvastatin, rosuvastatin, atorvastatin) ☐ Gallbladder Disease ☐ GERD (Acid Reflex) ☐ Headache/Migraines ☐ Heart Disease ☐ Statin Therapy ☐ Heart Valve Disorder ☐ Hepatitis/Liver Disease	☐ Hypertension ☐ Irritable Bowel Disease ☐ Myocardial Infarction (Heart Attack) ☐ Osteoporosis ☐ Renal Disease ☐ Seizure Disorder ☐ Stroke ☐ Thyroid Disease ☐ Tuberculosis ☐ Chronic Pain ☐ Opioid Use ☐ Other: _____

Past Surgeries/Recent Hospitalizations *(include emergency room and urgent care visits)*

Tobacco/Vaping Use Screening

Have you ever used tobacco?	☐ Yes ☐ No
Have you used tobacco in the last 30 days?	☐ Yes ☐ No
What type of tobacco have you used?	☐ Cigarettes/Cigars ☐ Pipe ☐ Chew ☐ Smokeless ☐ Snuff
Have you ever tried to quit using tobacco?	☐ Yes ☐ No
Do you vape?	☐ Yes ☐ No If yes, what device? _____ How often? _____
Have you ever had passive smoke or vaping exposure?	☐ Yes ☐ No

Alcohol Screening/Caffeine Use

Do you drink alcohol?	☐ Yes ☐ No ☐ Former Quit Date: _____
What type of alcohol?	☐ Beer & Liquor ☐ Beer & Wine ☐ Beer ☐ Hard Liquor ☐ Wine ☐ Other: _____
Frequency?	☐ Daily ☐ Occasionally ☐ Rarely ☐ Socially ☐ Other
Amount?	☐ ____ beer(s) ☐ ____ glass(es) ☐ ____ pack(s) ☐ ____ pints/bottles
How many times in the past year, have you had 4 or more drinks in a day?	☐ None ☐ 1-2 ☐ 3-5 ☐ > 5
Have you ever felt the need to cut down on drinking?	☐ Yes ☐ No
Ever felt annoyed by criticism of drinking?	☐ Yes ☐ No
Had guilt feelings about drinking?	☐ Yes ☐ No
Ever taken morning eye opener?	☐ Yes ☐ No
Do you drink/consume caffeine	☐ Yes ☐ No
What type of caffeine do you consume?	☐ Chocolate ☐ Coffee ☐ Energy Drinks ☐ Soda ☐ Tablets ☐ Tea
Physical Activity and Lifestyle	
What is your activity level?	☐ Sedentary ☐ Moderate ☐ Vigorous
Are you a health club member?	☐ Now ☐ Previously ☐ Never
What type of exercise do you do?	☐ Type: _____ ☐ I don't exercise
How often do you exercise?	☐ Daily ☐ 2-3x/week ☐ 4-5x/week ☐ Never
Fall Risk	
Have you had any problems with balance or walking in the last year?	☐ Yes ☐ No

Have you had more than one fall in the last year?	☐ Yes ☐ No If yes, number of falls: _____
Have you had an injury from a fall in the last year?	☐ Yes ☐ No

Gender & Sexual History

What is your sexual orientation?	☐ Heterosexual (straight) ☐ Homosexual (gay, lesbian) ☐ Bisexual ☐ I don't' know ☐ Other: _____
What is your current gender identity?	☐ Male ☐ Female ☐ Male to Female Transgender (Trans Female) ☐ Female to Male Transgender (Trans Male) ☐ Genderqueer (neither exclusively male or female) ☐ Additional or Other: _____ ☐ I choose not to disclose
Are you Sexually Active?	☐ Yes ☐ No
How many current sexual partners do you have?	☐ 0-1 ☐ 2-4 ☐ 5+
How many lifetime sexual partners do you have?	☐ 0-1 ☐ 2-4 ☐ 5+
Do you practice safe sex?	☐ Yes ☐ No

Your Family's Medical History *(list the conditions your family has/had)*

☐ Unknown/Adopted ☐ No relevant family history	☐ Alzheimer's or Dementia ☐ Asthma ☐ Cancer type: _____ ☐ Cardiovascular Disease ☐ Diabetes ☐ Hypertension ☐ Kidney Disease ☐ Other Please explain: _____ ☐ Storke

Psychosocial Health (Depression Screening) Over the past 2 weeks, how often have you been bothered by any of the following?

Little interest or pleasure in doing things?	☐ Not at All ☐ Several Days

	☐ More than half the days ☐ Nearly Everyday
Feeling down, depressed, or hopeless?	☐ Not at All ☐ Several Days ☐ More than half the days ☐ Nearly Everyday
Trouble Falling or staying asleep, or sleeping too much	☐ Not at All ☐ Several Days ☐ More than half the days ☐ Nearly Everyday
Feeling tired or having little energy?	☐ Not at All ☐ Several Days ☐ More than half the days ☐ Nearly Everyday
Poor appetite or overeating?	☐ Not at All ☐ Several Days ☐ More than half the days ☐ Nearly Everyday
Feeling bad about yourself- or that you are a failure or have let yourself or you family down?	☐ Not at All ☐ Several Days ☐ More than half the days ☐ Nearly Everyday
Trouble concentrating on things, such as reading the newspaper or watching television?	☐ Not at All ☐ Several Days ☐ More than half the days ☐ Nearly Everyday

Moving or speaking so slow that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual?	☐ Not at All ☐ Several Days ☐ More than half the days ☐ Nearly Everyday
Thoughts that you would be better off dead, or of hurting yourself in some way?	☐ Not at All ☐ Several Days ☐ More than half the days ☐ Nearly Everyday
Domestic Violence Screening	
Within the past year, or since you have been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone?	☐ Yes ☐ No
Are you in a relationship with a person who threatens or physically hurts you?	☐ Yes ☐ No
Has anyone forced you to have sexual activities that made you feel uncomfortable?	☐ Yes ☐ No
Women: Cervical Cancer Screening (ages 18+ years)	
Have you had a pap smear and/or HPV test in the past 3 years?	☐ Yes ☐ No ☐ Not sure Date: _____ Location: _____
Colorectal Cancer Screening *(all patients, ages 45+ years)*	
Have you had a fecal immunochemical (FIT) test in the last year? (FIT test: detects for human blood in your stool sample)	☐ Yes ☐ No Date: _____ Location: _____
Have you had a colonoscopy in the last 10 years?	☐ Yes ☐ No ☐ Not sure Date: _____ Location: _____
Women: Breast Cancer Screening *(ages 40+)*	
Have you had a mammogram within the last year?	☐ Yes ☐ No ☐ Not sure Date: _____ Location: _____
Men: Prostate Cancer Screening (ages 45+)	

Have you ever had a prostate specific antigen (PSA) blood test or digital rectal exam?	☐ Yes ☐ No ☐ Not sure Date: _____ Location: _____

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MEDICATION REFILL POLICY

Due to high volume of calls and prescription refill requests, we are kindly reminding patients:

1. **PLEASE DO NOT CALL OFFICE FOR MEDICATION REFILL, CONTACT YOUR PHARMACY.**

2. If you are not due for an appointment, and you have no more refills, then call your Pharmacy and request a refill, please allow 24-48 hours to process. Please do not wait until you are out of medication to request this refill.

3. **NO PAIN MEDICATION REFILL WILL BE GIVEN OVER THE PHONE OR FAX.** The pain contract implemented by provider will address to receive pain meds you must make an appointment with that provider. NO EXCEPTIONS.

4. If antibiotics are being requested, the patient must make an appointment.

5. If you have no more refills and you have an appointment coming up, bring that medication in to get refill at the time of visit.

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Retention of Health Records

In accordance with Arizona State Statute (A.R.S. § 12-2297), the Health Information Portability and Accountability Act (HIPAA) Privacy Rule (45CFR164.530) and NACA Policy IM 400, NACA Family Health Center and Behavioral Health Services retention of records are as follows:

- Health records that have been inactive for more than three (3) years will be transferred to the storage facility for retention as follows:

- For an adult, for at least seven (7) years after the last date the adult recipient received medical or behavioral health care services.

- For a child, either for at least three (3) years after the child's eighteenth birthday or for at least seven (7) years after the last date the child received medical or behavioral health care services, whichever is longer.

For deceased patients, for at least seven (7) years after the date of death.

After these dates, the records will be destroyed within HIPAA regulation of proper disposal.

It is the responsibility of each patient/client to obtain copies of their health records for their own records.

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PATIENT/CLIENT RIGHTS & RESPONSIBILITIES

Your individual treatment at this facility will be provided with consideration and respect, and you will not be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis.

Your privacy will be protected. Your examination, treatment, and discussions with your medical or behavioral providers will be kept confidential by the providers involved with your care. In addition, all communications and records pertaining to your medical care will be held in strict confidence, according to HIPAA regulations. You may approve or refuse the release of your medical record to any individual outside the facility, except as otherwise provided by law or third-party contract. You may review, upon written request, your medical record according to A.R.S.§ 12-2293, 12-2294, and 12-2294.01.

- You have the right to receive a referral to another health care facility if the NACA Family Health Center is unable to provide services for you, according to your medical/behavioral need.

- You have the right to request a change in providers if other qualified providers are available. Your request is subject to approval by the Medical Staff.

- You will know the identity and professional title of the healthcare team member(s) providing care for you.

- You have the right to refuse care provided by a student.

- You have the right to expect reasonable continuity of care, within the limitations of available appointment times and medical providers.

- You have the right to an interpreter.

- You will receive from your medical provider complete and current information regarding the diagnosis, treatment options and prognosis of your condition in terms that you can understand.

- You have the right and responsibility to participate in decisions involving your care.

- You have the right to participate in the development of and/or decisions concerning treatment.

- You have the right to refuse treatment to the extent allowed by law, and to be informed of the potential consequences of any such action. The consequences of refusing or not complying with recommended treatment may result in worsening illness or death.

- You have the right to refuse to participate in experimental research or treatment.

- You have the right to receive help from a family member, representative, or other individual in understanding, protecting, or exercising your rights.

- You have the right to receive an explanation of any bill coming from the NACA Organization.

- You have the right to file a complaint or grievance regarding the care received from NACA within 35 days of any incident or concern.

- Any patient/client or representative of a patient/client who has a concern regarding their visit to a NACA facility may submit a written or verbal request for resolution to:

  Native Americans for Community Action
  Quality Improvement & Compliance Director
  1500 E Cedar Ave. Ste 56, Flagstaff, AZ 86004
  Phone: (928) 526-2968

- You have the right to continue NACA services while in the process of complaint/grievance resolution and/or appeal.

- You also have the right to report grievances to other oversight agencies:

  Arizona Department of Health Services
  Division of Medical Facilities Licensing
  150 N. 18th Avenue, 4th Floor
  Phoenix, AZ 85007
  Phone: (602) 364-3030
  https://app.azdhs.gov/ls/online_complaint/MEDComplaint.aspx

  Health Choice Integrated Care (HCIC)
  1300 South Yale Street Flagstaff, AZ 86001
  Phone: (928) 774-7128

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Patients have responsibilities as well as rights. Patients can help themselves by being responsible in the following ways:

- You are responsible for keeping your appointments at NACA. If you cannot keep your appointment, it is your responsibility to notify NACA as early as possible so another person can be seen during that time.

- You have the responsibility to treat health care professionals with respect and consideration.

- You are responsible for being truthful and direct about anything related to your healthcare. It is your responsibility to tell your medical provider about any changes in your health.

- You are responsible for understanding your health problems. If you do not understand your illness or treatment, you are responsible to ask your medical provider.

- You are responsible for discussing your end-of-life decisions with your medical provider. This discussion might involve writing an advance directive.

- You are responsible for telling your medical provider if you are unable or unwilling to follow the treatment plan prescribed for you.

- You are responsible for knowing the names and uses of the medications you are taking.

- You are responsible for payment of services and/or co-payment on the day of service.

- You are responsible for applying for medical insurance.

- You are responsible for providing a responsible adult to provide transportation home and to remain with you as directed by the provider or as indicated on your discharge instructions.

Notice of Health Information Practices

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current, a Contexture company. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you to get better care?
In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure and timely manner.

What health information is available through Health Current? The following types of health information may be available:

- Hospital records
- Medical history
- Medications
- Allergies
- Lab test results
- Radiology reports
- Clinic and doctor visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment

Who can view your health information through Health Current and when can it be shared? People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, transition of care planning, payment for your treatment, conducting quality assessment and improvement activities, developing clinical guidelines and protocols, conducting patient safety activities, and population health services. Medical examiners, public health authorities, organ procurement organizations, and others may also access health information for certain approved purposes, such as conducting death investigations, public health investigations and organ, eye or tissue donation and transplantation, as permitted by applicable law.

Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted-use.

You also may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form.

Does Health Current receive behavioral health information and if so, who can access it?
Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from some substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the rest of your health information. Health Current will only share these protected substance abuse treatment records it receives from

these programs in two cases. One, medical personnel may access this information in a medical emergency. Two, you may sign a consent form giving your healthcare provider or others access to this information.

How is your health information protected?
Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.

Your Rights Regarding Secure Electronic Information Sharing You have the right to:

1. Ask for a copy of your health information that is available through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider.

2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.

3. Ask for a list of people who have viewed your information through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider. Please let your healthcare provider know if you think someone has viewed your information who should not have.

You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current:

1. Except as otherwise provided by state or federal law, you may "opt out" of having your information shared through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. Your information will not be available for sharing through Health Current within 30 days of Health Current receiving your Opt Out Form from your healthcare provider.
   Caution: If you opt out, your health information will NOT be available to your healthcare providers—even in an emergency.

2. If you opt out today, you can change your mind at any time by completing an Opt Back In Form and returning it to your healthcare provider.

3. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

IF YOU DO NOTHING, YOUR INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.

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HIPAA NOTICE OF PRIVACY PRACTICES EFFECTIVE 4/18/24

THIS NOTICE DESCRIBES HOW MEDICAL AND/OR BEHAVIORAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As part of the federal Health Insurance Portability and Accountability Act of 1996, also known as HIPAA, *Native Americans for Community Action, Inc.* (NACA) has created this Notice of Privacy Practices (Notice). This Notice describes NACA's privacy practices and the rights you, the individual, have as they relate to the privacy of your Protected Health Information (PHI). Your PHI is information about you, or that can be used to identify you, as it relates to your past and present physical and behavioral health care services. The HIPAA regulations require NACA to protect the privacy of your PHI NACA has received or created.

NACA will abide by the terms presented within this Notice. For any uses and disclosure not listed below, NACA will obtain a written authorization from you for that use or disclosure, which you will have the right to invoke at any time, as explained in more detail below. If you have any questions about this Notice, please contact our Director of Quality/Compliance Officer – (928) 526-2968 ext. 162 or at 1500 E Cedar Ave. Ste 56, Flagstaff, AZ 86004.

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 we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide behavioral health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- 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

PHI Editing and Deletion

We may edit your PHI in the following format:

- Correcting, amending, or retracting in paper records shall be crossed out neatly so as not to obscure the initial entry, and shall be initialed by the recorder. Use of white-out is not permitted. Any late entry into the medical record shall be documented as such.
- Electronic Health Records may only be corrected or amended by the Lead Medical Records Clerk or Clinical Coordinator. Any changes shall be specified in an addendum accompanied by a note.
- Examples of correcting, amending, or retracting include, but are not limited to, clerical errors (wrong person, wrong time, wrong date, wrong entry, etc.), scanned documents attached to the wrong record, or the record is missing information.

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.

1. 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. We may charge a reasonable, cost-based fee.
2. 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.
3. 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.
4. 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.
5. 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 (6) 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). We'll provide one (1) accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
6. 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.

7. 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.
8. File a complaint if you feel your rights are violated
    - You can complain if you feel we have violated your rights by contacting us using the information on page 1.
    - 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 visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
    - ADHS Medical Facilities at 150 N 18th Avenue, Phoenix, AZ 85007, phone (602) 364- 2536.
    - We will not retaliate or discriminate against you for filing a complaint.

Your Choices

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
- Include your information in a hospital directory

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
- Sale of your information
- Most sharing of psychotherapy notes in the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

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:

1. 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.
2. Run our organization
    - 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.

3. 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.**

1. 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
2. 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.
3. Respond to organ and tissue donation requests - We can share health information about you with organ procurement organizations.
4. Work with a medical examiner or funeral director - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
5. 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
6. 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 never share any substance abuse information without your written permission.
- We will never market or sell your personal 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 facilities, and on our web site

NACA
NATIVE AMERICANS
FOR COMMUNITY ACTION

Prompt Payment Fee Schedule

Payment for NACA services are due at time of service. The Family Health Center currently offers discount options for patients who would like to pay for their visit on the same day as their service. Please inquire with the Patient Service Coordinator as to the prompt pay discount.

Any services not paid for in full at the time of service will be considered overdue.

	Full Fee	Prompt Payment Fee (80% of full fee)
New Patient Office visit (99203)	$212.16	$170.00
Established Patient Office visit (99213)	$147.78	$118.00
New Minor Preventive (0-1 years)	$219.44	$176.00
New Minor Preventive (1-4 years)	$229.98	$184.00
New Minor Preventive (5-11 years)	$239.82	$192.00
New Minor Preventive (12-17 years)	$271.44	$217.00
Est Minor Preventive (0-1 years)	$198.36	$159.00
Est Minor Preventive (1-4 years)	$211.12	$169.00
Est Minor Preventive (5-11 years)	$210.42	$168.00
Est Minor Preventive (12-17 years)	$231.50	$185.00
New Adult Preventive (18-39 years)	$263.02	$210.00
New Adult Preventive (40-64 years)	$304.60	$244.00
New Adult Preventive (65+ years)	$331.06	$265.00
Est Adult Preventive (18-39 years)	$237.16	$190.00
Est Adult Preventive (40-64 years)	$252.58	$202.00
Est Adult Preventive (65+ years)	$271.44	$217.00
CPT for PHONE E/M PHYS/QHP 11-20 MIN (99442)	$89.72	$72.00
Influenza (Flu) Shot	$30.00	

NACA FAMILY HEALTH CENTER
AFTER HOURS CARE and REFERRAL POLICIES

After Hours Care Policy

- In case of a life-threatening emergency, please go directly to the Flagstaff Medical Center emergency room. Please refer to your individual insurance or AHCCCS plan guide for information on coverage of emergency room visits.

- For care that is less urgent, but that you feel needs evaluation while we are closed, you may go to local urgent care centers, or the Tuba City or Winslow Indian Health Center if you are Native American.

- NACA is not responsible for any bills you may have for after-hours care with other doctors, clinics, or hospitals.

Referral/ Contract Health Policy

- At times referrals are made for services not available at the clinic. These services may be consultation with a specialist, hospitalization, X-rays or tests, dental care, or eye care, etc.

- The NACA physician will contact your insurance company or your IHS Contract Health Services Office to inform them of the referral. This does not automatically mean that the referral has been approved by your private insurance or Contract Health Services.

- It is your responsibility to contact your insurance company or your IHS Contract Health Office to verify that the referral has been pre-authorized BEFORE your appointment. Only life-threatening emergencies do not need pre-authorization. Otherwise, you might be held responsible for the cost of the referral.

- To benefit from IHS Contract Health Services, it is important that you maintain a file at your IHS Indian Hospital. You will need a tribal census number and to update your information at least every five years. This can usually be done over the telephone. To qualify for coverage, you must notify your IHS Contract Health Office within 72 hours of an emergency room visit or hospital admission. There is no guarantee that they will pay for services.

NACA staff will assist you in obtaining any needed phone numbers and in clarifying any of the above. Thank you for your cooperation.

PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE® for Implementation as of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

	Yes		No		I choose not to answer this question

2. Which race(s) are you? Check all that apply

	Asian		Native Hawaiian
	Pacific Islander		Black/African American
	White		American Indian/Alaskan Native
	Other (please write):		
	I choose not to answer this question		

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

	Yes		No		I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

	Yes		No		I choose not to answer this question

5. What language are you most comfortable speaking?

Family & Home

6. How many family members, including yourself, do you currently live with? _____

	I choose not to answer this question

7. What is your housing situation today?

	I have housing
	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
	I choose not to answer this question

8. Are you worried about losing your housing?

	Yes		No		I choose not to answer this question

9. What address do you live at?
Street:_____
City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?

	Less than high school degree		High school diploma or GED
	More than high school		I choose not to answer this question

11. What is your current work situation?

	Unemployed		Part-time or temporary work		Full-time work
	Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:				
	I choose not to answer this question				

12. What is your main insurance?

	None/uninsured		Medicaid
	CHIP Medicaid		Medicare
	Other public insurance (not CHIP)		Other Public Insurance (CHIP)
	Private Insurance		

13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.

_____

	I choose not to answer this question

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14. In the past year, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? Check all that apply.

Yes	No	Food	Yes	No	Clothing
Yes	No	Utilities	Yes	No	Child Care
Yes	No	Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)			
Yes	No	Phone	Yes	No	Other (please write):
	I choose not to answer this question				

15. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

	Yes, it has kept me from medical appointments or
	Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
	No
	I choose not to answer this question

Social and Emotional Health

16. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

	Less than once a week		1 or 2 times a week
	3 to 5 times a week		6 or more times a week
	I choose not to answer this question		

17. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

	Not at all		A little bit
	Somewhat		Quite a bit
	Very much		I choose not to answer this question

Optional Additional Questions

18. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

	Yes		No		I choose not to answer this

19. Are you a refugee?

	Yes		No		I choose not to answer this

20. Do you feel physically and emotionally safe where you currently live?

	Yes		No		Unsure
	I choose not to answer this question				

21. In the past year, have you been afraid of your partner or ex-partner?

	Yes		No		Unsure
	I have not had a partner in the past year				
	I choose not to answer this question				

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