Notice of Privacy Practices

Your Information.

Your Rights.

Our Responsibilities.

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

As a part of our responsibilities, all employees and patients of Shasta Community Health, Dental, and Maternity Centers will follow this notice.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Ask for details to be fixed on your paper or electronic medical record
- Ask for confidential, or private, communication
- Ask us to limit the details we share
- Get a list of who we have shared your information with
- Get a copy of this privacy notice
- Choose someone to act for you (such as a Healthcare Proxy, or someone with Power of Attorney)
- File a complaint if you believe we have failed to protect your privacy rights

***See page 2 and 3** *for details on these rights and how you can use them.*

Your Choices

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

- Talk to your family and friends about your health
- Give disaster relief
- Place you in our clinic directory, unless you let us know that you object
- Give mental health care
- Market our services and sell your information

***See page 4** *for details on these choices and how to choose them.*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our health care center
- Bill for services we give you
- Help with public health and safety issues
- Do research
- Follow with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

***See page 5 and 6** *for details on these uses and disclosures.*

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our duties to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. SCHC requires this request to be in written form. Authorization to Release Information Form • We will give you a copy or a summary of your health information, usually within 15 days of your request. We may charge a fair fee for labor plus $0.25 per page. This fee cannot exceed $6.50, with postage, labor, and supplies. (Health and Safety Code Section 123110) • You can ask SCHC to send your electronic e-health record to a third party. SCHC may only charge for labor costs. • We can deny access to all or part of your medical record. We must give a written reason within 5 working days.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is wrong or incomplete. Ask us how to do this. Medical Record Amendment Form • We may say "no" to your request, but we will tell you why in writing within 60 days.
Request confidential communications	• You can let us know how you would like to be contacted, for example: by home or office phone, or to send mail to a different address. Request for Confidential Communications Form • We will say "yes" to all fair requests.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. Request for Restriction of Health Record Form • If you pay out of your own pocket for a health care service or item, you can ask us not to bill your health insurance plan. • We will say "yes" unless a law requires us to share that information.

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Get a list of who we have shared your information with	• You can ask for a list of times we have shared your health information for up to six years before the date you ask. We will tell you who we shared it with, and why. We will also tell you if we were legally required to without your express consent. Examples of why we would do this are for the California Department of Public Health, or other licensing body, and for the purpose of reviewing patient files to review quality of care and compliance with the law. [Request for Accounting of Protected Health Information Disclosures Form] • We will give you a list of all of the times we have shared your information, except for those about treatment, payment, and health care operations, and certain other times (such as any you asked us to make). The first request in a year is free, but we may charge a fair fee based on our cost if you make another request within 12 months.
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 get the notice electronically. We will give you a paper copy as soon as possible.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, or healthcare proxy, that person can exercise your rights and make choices about your health information. • We will make sure that person has this authority and can act for you before we take any action.
File a complaint if you feel we have failed to protect your rights	• You can complain if you feel we have failed to protect your rights. You must make your complaint in writing within 180 days (6 months) of when you suspect it happened. Give as much detail as you can. To submit a grievance: 1. Go to www.shastahealth.org. 2. Navigate to the upper right-hand corner of the homepage and click on "Submit a Grievance." 3. On the next page, fill in all parts of the Patient Grievance Resolution form. 4. After submitting your grievance, be sure to copy down the 12-digit "Report Key" provided to you. This key will allow you to follow up on your grievance, to send additional information, and to attach documents if you need to. 5. You will be notified after your grievance has been received and we will respond to your grievance within 30 days. • You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights one of three ways: 1. Mail: 200 Independence Ave., S.W., Washington, D.C. 20201 2. Phone: 1-877-696-6775 3. Online: http://www.hhs.gov/ocr/privacy/hipaa/complaints/ • We will not take action against you for filing a complaint.

Your Choices

For certain health information, you can tell us what you want to share. You can tell us how you want us to share your information in the situations listed below. Let us know 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.
- Take away this consent at any time. This can be done by telling us verbally or in writing.
- Share information in a disaster relief situation
- **Health Information Exchange** - We can share your data with a Health Information Organization (HIO). Your data will be made available by the HIO to others involved in your health care, unless you choose not to allow them access. You can do this by filling out the Opt-out form found on the SACVALLEY MEDSHARE website: http://sacvalleyms.org/.
- **Appointment Reminders** - If we call you to remind you of an appointment at one of our health centers, we will only leave the name of the center and the time of appointment. Please let us know if you do NOT wish to be called or contacted by mail.

  Request for Confidential Communications Form

  You may ask to be contacted in other ways like text message or email.

  Communication Preferences Form

If you are not able to tell us what you would like, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to help with a serious and impending threat to health or safety.

We never share your information unless you give us written consent when you are seen for these reasons only:

- Most psychotherapy notes
- HIV status
- Substance use

How do we typically use or share your health information?

Most of the time we use or share your health information in these ways:

Treat you (Treatment)	• 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.*
Bill for your services (Payment)	• 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.*
Run our health centers (Operations)	• We can use and share your health information to run our health centers, improve your care, and contact you when needed.	*Example: We use health information about you to manage your treatment and services.*

What other ways we can use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that help 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 reasons. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	• We can share health information about you for certain reasons such as: • Preventing disease • Helping with product recalls • Reporting bad or severe reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Business associates	• A business associate is a person or group of people that do jobs or tasks that involve the use or sharing of protected health information (PHI) for a covered entity. SCHC is a covered entity. These business associates are held to the following standards: • All HIPAA (Health Information Portability and Accountability Act) security administrative safeguards • Physical and technical safeguards • Security policies, procedures, and documentation requirements

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Do research	• We can use or share your information for health research.
Follow 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 they want to see that we are following federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ collection organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director if you pass away.
Address worker's 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 • For correctional facility purposes • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to an order to attend court (a subpoena).

Our Responsibilities

- We are required by law to keep the privacy and security of your protected health information (PHI).
- It is our duty to protect the privacy of all our patients. We must also protect our employee's privacy. It is against SCHC policy and California law to purposely record or take pictures of confidential information by way of an electronic device or recording device (including cell phones) unless express consent is given by your clinician.
- We will let you know right away if a breach occurs that may have compromised the privacy or security of your information.

continued on the next page

- SCHC is including HITECH (Health Information Technology for Economic and Clinical Health) Act provisions to its Notice as follows:

  Under HITECH, SCHC is required to notify you if your PHI has been breached. This notice has to be made by certified mail within 15 days of the event. A breach occurs when an unauthorized use or disclosure that compromises the privacy or security of PHI poses a significant risk for financial, reputational, or other harm to the individual. In other words, a breach is when someone gains access to or shares your PHI without your consent. This could put you at greater risk for fraud, harm your identity, or could impact you in other harmful ways. This notice must:

  1. Give details of what happened, including the date of the breach and the date of the discovery
  2. Have the steps that you should take to protect yourself from any harm that might result from the breach
  3. Give details of what SCHC is doing to investigate the breach, reduce losses, and to protect against further breaches

- We must follow the duties and privacy practices listed in this notice and give you a copy of it.
- We will not use or share your information other than as listed here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

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

Other Instructions for this Notice

This notice is effective January 1, 2019. Previous versions were effective April 1, 2003 and amended February 17, 2010, and January 1, 2017.

For questions regarding this notice, contact:

Privacy Officer
1035 Placer Street
Redding, CA 96001
Phone: (530) 246-5986
privacy@shastahealth.org

MRN: ______________

Employee ID #: ______________
Office Use Only

Notice of Privacy Practices: Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" of Shasta Community Health Center (SCHC). Our "Notice of Privacy Practices" tells you how we may use and share your protected health information. We encourage you to review it carefully.

We may change our "Notice of Privacy Practices." If we change our notice, you may get a copy of the revised notice at any of our locations, by calling (530) 246-5710, or online at www.shastahealth.org.

If you have any questions about our "Notice of Privacy Practices," please contact our Privacy Officer by phone at (530) 246-5986 or by email at privacy@shastahealth.org.

I acknowledge receipt of the "Notice of Privacy Practices" of SCHC.

Patient Name: Date:

Sign Here:

Relationship: ☐ Patient ☐ Parent ☐ Guardian/Legal Representative ☐ Foster Parent

If signing for the patient, print your name:

MRN: ____________

Employee ID #: ____________
Office Use Only

Patient Registration

Personal Information: Give us some details about the patient so we can get to know them better.

Patient Information

Last Name: ____________________ First Name: ____________________ Middle Initial: _____

Date of Birth: ______________________ Social Security #: ______________________

Gender at Birth: ☐ Male ☐ Female

Mailing Address: ____

City: ______________________________ State: _______ Zip Code: ____________

Physical Address (if different): ____

City: ______________________________ State: _______ Zip Code: ____________

Home Phone: ___________________ Work Phone: ______________________

Cell Phone: ___________________ Email Address: ___________________________________

Are you a veteran?
☐ Yes ☐ No

Are you homeless or at risk of being homeless? ☐ Yes ☐ No

Race? (Check all that apply):

☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese

☐ Other Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro

☐ Samoan ☐ Black/African American ☐ American Indian/Alaskan Native ☐ White

☐ More than one race ☐ Don't know or don't want to say

Ethnicity?

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban

☐ Other Hispanic or Latino/a ☐ Not Hispanic or Latino/a ☐ Don't know or don't want to say

What language do you prefer?

☐ English ☐ ASL ☐ Spanish (Español) ☐ Mien (Mienh) ☐ Other: ______________________

Would you like to have an interpreter during your medical visits? ☐ Yes ☐ No

MRN: ______________

Employee ID #: ______________
Office Use Only

Parent/Legal Guardian Information

Only needed if patient is under 18

Parent/Legal Guardian #1: ________________________________ Birthdate: ____________

Type of Parent: ☐ Biological ☐ Adoptive ☐ Foster ☐ Other: ______________________

Parent/Legal Guardian #2: ________________________________ Birthdate: ____________

Type of Parent: ☐ Biological ☐ Adoptive ☐ Foster ☐ Other: ______________________

Financial & Insurance Information: Here we need the details about the account holder. This is the person that will be paying for services.

Patient Insurance: ☐ Medicare ☐ Medi-Cal ☐ Private Insurance

☐ Other: ____

Account Holder or Person Paying

Insurance is asked to pay first. Sometimes there is still money owed.
Who should we send statements to? (Statements may include limited personal health information.)

☐ Patient ☐ Other

If you marked other, please fill out the details below:

Last Name: ____________________ First Name: ____________________ Middle Initial: _____

Relationship to Patient: ____

Mailing Address: ____

City: ____________________________ State: _______ Zip Code: ____________

Home Phone: ____________________ Work Phone: ______________________

Cell Phone: ____________________ Email Address: ________________________________

Sign Here: By signing here you are agreeing that the details given on this form are true and correct.

Patient or Account Holder: ____ Date: ___________

MRN: ______________

Employee ID #: ______________
Office Use Only

My Consent for Care

Thank you for seeking care from Shasta Community Health Center (SCHC). SCHC is a Federally Qualified Health Center and Integrated Teaching Health Center. Our sites include Shasta Community Health Center and Shasta Community Maternity Center in Redding, Anderson Family Health Center, Shasta Lake Family Health Center, and all SCHC Dental Centers. For a complete listing of all SCHC locations and clinicians, please go to www.shastahealth.org.

This Consent for Care Agreement authorizes SCHC to provide you with medical, specialty, or dental care. This form must be signed before you can be treated. The only exception is in cases of emergency.

By signing this form:

1. I consent to diagnosis, care and treatment that is considered necessary or recommended by my clinician(s) and other healthcare clinicians.
2. I understand that my consent will be carried over to other SCHC locations, if I choose another clinician or service within SCHC.
3. I understand that SCHC is a Teaching Health Center. I understand this means that physician and dental residents, nurse practitioner fellows, physician assistant fellows, and other licensed healthcare professionals "in training" may be involved in my care and treatment.

I have read, understand and agree to this Consent for Care agreement.

Patient Name:	Date:
Sign Here:	
Relationship: ☐ Patient ☐ Parent ☐ Guardian/Legal Representative ☐ Foster Parent	
If signing for the patient, print your name:	

MRN: ______________

Employee ID #: ______________
Office Use Only

Communication Preferences

Tell us how you would like us to communicate with you. We will be in contact about appointment reminders, preventative healthcare you may be due for, and messages from your healthcare team.

NOTE: Regular text messaging is not secure. This means there may be some risk that information could be read by someone else besides you. For that reason, we are required by law to obtain your consent if you want to receive text messages from SCHC.

Phone Preferences

☐ I want to receive phone calls from SCHC at my:

Home phone number: (_______)______________________

☐ I want to receive voice messages at my home number, and I understand that no protected health information (PHI) will be left in the message.

Cell phone number: (_______)______________________

☐ I want to receive voice messages at my cell number, and I understand that no PHI will be left in the message.

☐ I DO NOT want to be contacted by phone

Text Messaging Preferences

☐ I want to receive text messages at this number: (_______)______________________
I know it is my responsibility to let SCHC know right away if my number changes. I also know that such messages cannot be sent securely and I risk information being disclosed.

☐ I DO NOT want to receive text messages

Patient Portal

We use a patient portal called Shasta Health Connect (SHC). With SHC you can send and receive secure email, request appointments, request medication refills, and review your recent labs results and medical records. **This is the best option for being able to securely and safely receive and discuss PHI with your health care team.**

In order to sign up, you must provide an email address. Would you like to sign up today?

☐ Yes, my email address is: ____

☐ No, I do not want to sign up at this time

Patient Name:	Date:
Sign Here:	
Relationship: ☐ Patient ☐ Parent ☐ Guardian/Legal Representative	
If signing for the patient, print your name:	

MRN: ______________

Employee ID #: ______________
Office Use Only

How We Share Protected Health Information (PHI)

Shasta Community Health Center (SCHC) has safeguards in place to protect our patients' medical and private information. Our mission is to give quality health care and make sure your privacy needs are met.

Do I need to fill this form out?
Yes, we need to know your Emergency Contact. Listing anyone else is optional. SCHC will only share your PHI to assist us in your treatment, to share minimum necessary information for payment from your insurer or other sources, and in our operations designed to ensure the quality of care you receive. This includes sharing only necessary information with those you choose. Here is how we define those support roles:

1) **Emergency Contact**—This is someone we can share information with *only* in the event of an emergency. If you wish to share information more freely, please select Caregiver.
2) **Next of Kin**—This is a relative who we can share information with only in the event where you are incapacitated (unable to speak for yourself). If you wish to share information more freely, please select Caregiver.
3) **Caregiver**—This is *anyone* who you feel comfortable with sharing information with, such as a relative, close friend, or home care aide. You don't necessarily need to be dependent on them for daily living in order to designate them as someone who is part of your care. We may need to use our professional judgement to decide whether someone is a caregiver and if sharing your PHI with them would be best for your care.

What if I want to make sure my caregiver can get copies of my record?
You can fill out the *Authorization to Release Health Records* form to request your medical record in paper or electronic format to share with your caregiver or relative.

What if I do not want my PHI shared with a certain person or doctor's office?
You can ask to restrict the use or sharing of your PHI by filling out the *Request for Restriction of Health Record* form if you do not want your PHI shared with a certain person, such as your caregiver or other health care provider.

More questions? Please review SCHC's *Notice of Privacy Practices*.

First and Last Name:			
Phone Number:		Relationship to Patient:	
Support Role:	☐ Caregiver	☐ Next of Kin	☐ Emergency Contact
First and Last Name:			
Phone Number:		Relationship to Patient:	
Support Role:	☐ Caregiver	☐ Next of Kin	☐ Emergency Contact

Patient Information:

Patient Name:		Date:	
Sign Here:			
Relationship:	☐ Patient	☐ Parent	☐ Guardian/Legal Representative
If signing for the patient, print your name:			

MRN: ______________

Employee ID #: ______________
Office Use Only

Patient Health History - Dental

Patient name: ______________________________ Today's date: ________________

Nickname: ______________________________ Date of birth: ________________

1. Please circle Yes or No (leave blank if you do not understand the question):

Yes / No Do you smoke?

Yes / No Is your general health good?

Yes / No Has there been a change in your health within the last year?

Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?

Yes / No Do you take blood thinners?

Yes / No Are you being treated by a clinician now?

Date of last medical exam: ________________

Reason for exam: ______________________________

Yes / No Have you had problems with prior dental treatment?

If yes, please explain: ______________________________

Date of last dental exam: ________________

Yes / No Are you in pain now?

2. Do you have any of the following conditions? (Please circle Yes or No for each)

Yes / No	Chest Pain (angina)	**Yes / No**	Excessive thirst
Yes / No	Blood in stools	**Yes / No**	Night sweats
Yes / No	Frequent vomiting	**Yes / No**	Difficulty swallowing
Yes / No	Fainting spells	**Yes / No**	Persistent cough
Yes / No	Artificial joint	**Yes / No**	Coughing up blood
Yes / No	Jaundice	**Yes / No**	Swollen ankles
Yes / No	Artificial heart valve or stent	**Yes / No**	Bleeding problems
Yes / No	Fever	**Yes / No**	Bruise easily
Yes / No	Dizziness	**Yes / No**	Sinus problems
Yes / No	Recent significant weight loss	**Yes / No**	Shortness of breath
Yes / No	Difficulty urinating	**Yes / No**	Blurred vision
Yes / No	Blood in urine	**Yes / No**	Pain in the mouth
Yes / No	Dry mouth	**Yes / No**	Other: ________________

3. Do you have or have you ever had any of the following? (Please circle Yes or No for each.)

Yes / No	Surgeries Date of surgeries: __________________	**Yes / No**	Arthritis/Rheumatism
Yes / No	Heart disease / heart surgery	**Yes / No**	Stomach problems or ulcers
Yes / No	Heart murmur or heart valve defect	**Yes / No**	Rheumatic fever
Yes / No	Heart attack	**Yes / No**	Eye disease
Yes / No	Pacemaker Date implanted: _____________	**Yes / No**	Transplant
Yes / No	Skin disease	**Yes / No**	G-tube (feeding tube)
Yes / No	Anemia	**Yes / No**	Psychiatric care
Yes / No	Osteoporosis	**Yes / No**	Thyroid disease
Yes / No	Taking bisphosphonates (Fosomax, Actonel, Boniva, Prolia)	**Yes / No**	Asthma
Yes / No	High blood pressure	**Yes / No**	Hepatitis
Yes / No	Seizures	**Yes / No**	Tumors or cancer
Yes / No	Stroke	**Yes / No**	Chemotherapy
Yes / No	Cosmetic surgeries	**Yes / No**	Radiation
Yes / No	AIDS/HIV	**Yes / No**	Liver disease
Yes / No	Sexually transmitted disease	**Yes / No**	Kidney or bladder disease
Yes / No	Herpes	**Yes / No**	Eating disorder
Yes / No	Canker or cold sores	**Yes / No**	Tuberculosis
Yes / No	Organ transplant	**Yes / No**	Diet medications
Yes / No	Diabetes	**Yes / No**	Alcohol or substance use
Yes / No	Emphysema or other lung disease	**Yes / No**	Hives

4. **Are you allergic to or had a reaction to any of the following? (Please circle Yes or No.)**

Yes / No Aspirin	**Yes / No** Latex
Yes / No Codeine or other opioids	**Yes / No** Food
Yes / No Nitrous oxide	**Yes / No** Metal
Yes / No Valium or sedatives	**Yes / No** Local anesthetic
Yes / No Penicillin or other antibiotics	**Yes / No** Other allergies: ______________ ______________

5. **Do you have or have you had any diseases or medical problems NOT listed on this form? Yes / No**

If Yes, please explain: ______________________________

____

____

6. **Women:**

Yes / No Are you taking birth control?

Yes / No Are you or could you be pregnant? **If yes, how many months?** __________

Yes / No Are you nursing?

7. **Medications:**

Name of the Medicine	**Dose**
1.	
2.	
3.	
4.	
5.	

Patient Name: Date:

Sign Here:

Relationship: ☐ Patient ☐ Parent ☐ Guardian/Legal Representative

If signing for the patient, print your name:

Dental Office Notes: ______________________________

____

____

____

DDS Signature: ______________________ **ASA:** ______________

Sliding Fee Discount Program
For Medical and Dental Services

Please read this before completing the Sliding Fee Discount Program Application.

Shasta Community Health Center's mission is to provide quality health and dental care services to everyone. We are a private, nonprofit, federally funded health care program with locations in Redding, Anderson, and Shasta Lake. We bill most insurances and we accept patients without regard to their financial status. We offer a wide range of services to patients through the sliding-fee discount program. This program helps ensure that cost is not a barrier to anyone in our community seeking health care services.

To determine your eligibility for this federally funded program, documentation of your income (or lack of income) and household size is required. You must update this information at least annually to continue your participation in the program. This information is only used to calculate your discount and is kept completely confidential. If you have a high insurance deductible, you may be eligible for the Sliding Fee Discount Program.

If you qualify for the sliding fee program, you will be required to pay a minimum fee of $15.00 - $55.00. Your payment is due at the time of service.

You must complete the financial information form every year to determine your eligibility and discount. This information includes:

- ✓ Your total household income from all sources before taxes.
- ✓ Number of household members living in your household.
- ✓ You may be asked to provide proof of your total household income. This can be in the form of check stubs, bank statement, tax returns, or any other document that proves your household income.

Your discount may change if your income or family size changes.

Sliding Fee Discount payments may be refundable whenever SCHC receives payment from your insurance for that date of service.

Services offered under the SCHC Sliding Fee Discount Program are limited to those deemed medically necessary by appropriate Center staff. Cosmetic, elective, or job-mandated health services do not qualify for the Sliding Fee Discount Program.

Labs, Radiology, and Special Procedures:

If you qualify for our Sliding Fee Discount Program, your labs are covered if you have them done by Quest Diagnostics. If you do not qualify and you are self-pay, you must pay a discounted "council fee" at the time of checkout with a visit coordinator.

There are separate charges for performing and reading an x-ray. MD Imaging (MDI) offers a discount program, but it is a separate program. Please make discount arrangements directly with MDI.

Your health care provider may order special diagnostic studies (such as a sonogram or CT) not performed at SCHC. You will be responsible for 100% of those charges and must arrange to pay the facilities that provide them.

Please let us know if you have any questions about our programs or services. We are here to help! You can contact our Billing Department at (530) 246-5934.

HOH MRN: ______________

Employee ID #: ______________
Office Use Only

Sliding Fee Application

Personal Information: Give us some details about you and your household.

Patient Information

Last Name: ______________________________ First Name: ______________________________

Middle Initial: _____ Date of Birth: ________________

Address: ____

City: ______________________________ State: _______ Zip Code: ___________

Head of Household

This is usually the person who makes the most money in the home.

Same as patient? ☐ Yes ☐ No - If no, please let us know who is Head of Household:

Last Name: ______________________ First Name: _____________________ Middle Initial: ____

Relationship to Patient: ________________________________ Date of Birth: ________________

Other People in the Household *(People who share all money made and bills - children too)*	**Relationship to Head of Household**	**Date of Birth**
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
TOTAL MEMBERS OF HOUSEHOLD		

HOH MRN: ______________

Employee ID #: ______________
Office Use Only

Financial & Household Information: Tell us how much money you and the people in your household make.

Section A: How much money is made from all jobs, including self-employment?

☐ Monthly $ ________________

☐ Weekly $ ________________

☐ Every 2 Weeks $ ________________

☐ Twice a Month $ ________________

TOTAL (A)	**$**

Section B: Other Sources of Money	**Monthly Total**
Child Support/Alimony	$
Unemployment	$
Disability/Workers Comp	$
Interest/Dividends	$
Social Security/SSI/Survivors Benefits	$
Pensions	$
Rental Income	$
Public Assistance *(not food stamps)*	$
Education Assistance	$
TOTAL (B)	**$**

Sign Here: By signing below you are saying that you agree to the statement in the box.

I know that giving false information may disqualify me for discounts. I also know, if disqualified, I will have to pay for the full fee and will not be eligible for the Sliding Fee Program.

I know that just because I apply for a discount does not mean I will get a discount. I also know that if I do not tell SCHC about any changes to how much money I make or the amount of people in the house, SCHC may immediately take away any discounts.

I know that information on this form will only be shared internally for purposes of the Sliding Fee Program.

Person Responsible for Paying

Sign: ______________________________ **Date of Birth:** ______________

Name & Relationship: ______________________________ **Date:** ______________

This form does not bind other agencies to honor the given discount and they may ask for more information.

--- OFFICE USE ONLY ---

Take the number reported in (A) and times it by the appropriate amount to get (A*)
Weekly: x 4.33 Every 2 Weeks: x 2.167 Twice a Month: x 2

Household size: ______________	Monthly Income: Wages (A*): $ __________ Other (B): $ __________ **TOTAL: $** __________ **(A* + B)**	Category: ______________ (A, B, C, D or Self) Fee: $ __________	Total Annual Income: $ ______________
Reviewed By: ______________________		O&E Referral: __________	Expiration Date: __________

MRN: ______________

Employee ID #: ______________
Office Use Only

Financial Policy

For Medical and Dental Services & Fees

We feel that a part of good health care is having a clear financial policy that is shared with our patients. Please take time to review this policy. We want to make sure you understand it. Financial details can be confusing. Let us know if you need us to explain anything.

Payment: Here are some details that you should know about our payment policy.

Any fees that you need to pay are due at the time of your visit. This policy is for patients with or without health insurance.

We will take cash, check, or credit card.

If you have insurance, your payment includes any un-paid:

- ✓ Deductibles
- ✓ Co-insurance
- ✓ Co-payment amount
- ✓ Non-covered fees from your insurance company

We ask for a copy of an ID card or license to help protect you from identity theft.

Self-Pay or Prompt Pay Patients (pay at your visit) Who have insurance:
Did you know that if you pay for your medical fees at the time of your visit, you may qualify for a 50% discount?

- ✓ You don't need insurance to qualify
- ✓ This does not include dental fees

Insurance: Here are some details that you should know about insurance.

We are a participating provider or considered in-network with a few plans; find out if we are with your plan by contacting your insurance company.

Learn what services and clinicians are covered before your visit by calling your insurance benefits department.

If our clinicians or services are not listed in your plan's network (on their list of clinicians or services they have a contract with):

- ✓ You may have to pay for part of, or the entire bill.
- ✓ We will send the claim to your insurance for you.
- ✓ Your insurance might send the payment for you to bring and pay at your SCHC visit.

You must bring your insurance card to every visit. We will need to copy both sides.

If you have insurance, we will send them the bill.

If you do not have insurance we will send the bill to you.

If the insurance does not cover the fees the patient will need to pay. If we get a payment from your insurance after you pay, we will refund what is due to you.

MRN: ______________

Employee ID #: ______________
Office Use Only

If you are a member of a HMO or managed care plan:
You must see your primary care provider (the clinician you see for your general health care).
If your insurance does not cover part of your fee:
You might qualify for our sliding fee discount program for the things that are not covered. Medical and Dental have different rules.

Other Notes: Here are some other things to think about.

Diagnostic tests are billed separately.
If you are referred to another provider or other services, any bills or fees you get from them will be between you and them. They may bill differently than we do at SCHC.

If you have questions about your bill or fees

Our Billing Team is happy to help! You can call us at (**530) 246-5934**.

Sign: By signing below you are saying that you have read and understand the details of the SCHC Financial Policy.

Patient Name:	Date:
Sign Here:	
Relationship: ☐ Patient ☐ Parent ☐ Guardian/Legal Representative	
If signing for the patient, print your name:	

Save on Your Prescription Drugs

While Supporting Your Community

Did you know Shasta Community Health Center (SCHC) is part of the 340B Drug Discount Program?

What This Means:

- Lower cost drugs if you don't have insurance
- Better communication between your pharmacy and your clinician
- Supporting your local community health center

SCHC is a Federally-Qualified Health Center which allows us to share this program with our patients. Show your 340B card at a pharmacy in the SCHC Pharmacy Network and you could save money while supporting your community health center. Patients who don't have insurance may get drugs at a lower cost. Patients with insurance get benefits through expanded services at SCHC.

Ask us for your 340B Card today!

SHASTA COMMUNITY HEALTH CENTER

Patient Name____________________
Exp. Date____________________
Prescription Discount Card

Rite Aid, Safeway, or Raley's		CVS Pharmacy	
BIN	610724	BIN	017515
PCN	CRX		
Group	CAP35	Group	SHCH1000
Member ID	1020892	Member ID	999999999

SHASTA COMMUNITY HEALTH CENTER
Sliding Fee Card

Patient Name____________________
Exp. Date____________________
Prescription Discount Card

Rite Aid, Safeway, or Raley's		CVS Pharmacy	
BIN	610724	BIN	017515
PCN	CRXSF		
Group	CAP35	Group	SHCH3000
Member ID	1027054	Member ID	999999999

Note: The blue and white card is available to all patients. The yellow and white card is for uninsured patients who are eligible for our sliding fee.

Look on the back for a list of pharmacies that accept this program. →

SCHC 340B Pharmacy Network:

CVS Pharmacy	
1060 E. Cypress Avenue, Redding	(530) 221-5575
3375 Placer Street, Redding	(530) 241-7328
1035 Placer Street, Suite 110, Redding	(530) 999-6073
2025 Court Street, Suite A, Redding	(530) 999-6072
317 Lake Boulevard, Suite B, Redding	(530) 999-6099
1280 Dana Drive, Redding (Inside Target)	(530) 224-1437
2975 East Street, Anderson	(530) 744-6024
455 South Main Street, Red Bluff	(530) 529-5530
1311 South Main Street, Weaverville	(530) 623-5555
Raley's	
201 Lake Boulevard, Redding	(530) 246-3511
Rite Aid Pharmacy	
3095 McMurray Drive, Anderson	(530) 365-5753
975 East Cypress Avenue, Redding	(530) 223-3995
6424 Westside Road, Redding	(530) 243-3616
1801 Eureka Way, Redding	(530) 243-5500
5350 Shasta Dam Boulevard, Shasta Lake	(530) 275-1532
Safeway Pharmacy	
2275 Pine Street, Redding	(530) 247-3040
1070 East Cypress Avenue, Redding	(530) 222-8274
2601 Balls Ferry Road, Anderson	(530) 365-1010
Walgreens Pharmacy	
980 East Cypress Avenue, Redding	(530) 221-5028
1775 Eureka Way, Redding	(530) 241-3294
115 Lake Boulevard, Redding	(530) 229-1519