CHCFC
Community Health Center of Franklin County

New Patient Welcome Packet

Please fill out and return to CHCFC

Greenfield Medical & Dental
102 Main Street
Greenfield, MA 01301

Tel: (413) 325 - 8500

Urgent Dental Care
164 High Street
Greenfield, MA 01301

Tel: (413) 325 - 8700

Orange Medical & Dental
119 New Athol Road
Orange, MA 01364

Tel: (978) 544 - 7800

WELCOME TO THE COMMUNITY HEALTH CENTER OF FRANKLIN COUNTY!

I am so glad you are here. CHCFC is not just a "regular" doctor's office. We are proud to do things a little differently. We are a nonprofit organization, which means we are driven by mission instead of by profit. No one owns this company, because it belongs to the entire community. It belongs to you.

We strive to deliver high quality healthcare to all of our community members with respect, not judgment. No one should be left out. As a Federally Qualified Health Center (FQHC) we have quality control programs and a Board of Directors made up of community members, the majority of whom are patients here. If you are interested in applying to serve on the Board, please let us know by emailing info@chcfc.org.

At CHCFC, we are here for you if you're sick, but we also want to help you achieve your best health. We are located in Greenfield and in Orange, and we offer a variety of services including dental, medical, behavioral health, pediatrics, addiction, and sexual and reproductive health care. Good health sometimes means medicine, but it can also mean social connection, a ride to your appointment, a safe environment, help with your insurance, exercise, nutritious foods, a language interpreter, and so much more. As a patient of the Health Center, you have access to resources and programs that support your whole health. Please let us know what you need, so we can connect you.

Choosing an FQHC office like ours means receiving patient-centered healthcare- and it comes with the best side effect: when we serve you, you are supporting *your* community health center.

Let us know if you have any questions, concerns, or suggestions. It is a privilege to be your healthcare partner.

Sincerely,

Allison van der Velden
CEO

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Patient Registration Form

Date: _____

Please register me for:	☐ Medical Services	☐ Dental Services	☐ Behavioral Health Services
Location:	☐ Greenfield	☐ Orange	☐ Baystate (Urgent Dental Only)

Patient Information

Today's Date: _____
Legal Name (First & Last): _____
Preferred/Current Name: _____ Pronouns: _____
Sex Assigned at Birth*: ☐ Female ☐ Male
**While CHCFC recognizes a number of genders/sexes, many insurance companies and legal entities do not. Please know that we are required to use the name and sex listed on your insurance for documents related to insurance, billing and correspondence. During your visit and everywhere else we'll use your current name and pronouns.*
Date of Birth: _____ SSN: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Phone 1: _____ ☐ Cell ☐ Home ☐ Work
Phone 2: _____ ☐ Cell ☐ Home ☐ Work
Email Address: _____

Emergency Contact Name: _____
Relationship: _____ Phone: _____

Preferred Pharmacy: _____

Insurance and Payment Information

Do you have Medical Insurance? ☐ Yes ☐ No
Name of Policy Holder: _____ Date of Birth: _____
Relationship to Policy Holder: _____
Primary Plan: _____ Policy/ID Number: _____
Secondary Plan:_____ Policy/ID Number: _____

Do you have Dental Insurance? ☐ Yes ☐ No
Primary Plan: _____ Policy/ID Number: _____
Secondary Plan:_____ Policy/ID Number: _____

Would you like to apply for our sliding fee scale? ☐ Yes
Would you like help with insurance enrollment? ☐ Yes

Turn Over!

Demographic Information

As a health center that receives Federal funding, we are required to collect this information. All answers are confidential.

Race (check all that apply)
☐ Asian ☐ American Indian or Alaska Native ☐ Black
☐ Native Hawaiian or Pacific Islander ☐ White

Ethnicity
☐ Hispanic/Latino/Latinx ☐ Non-Hispanic

Marital Status
☐ Married/Partnered
☐ Single
☐ Divorced
☐ Legally Separated
☐ Widowed

Gender Identity
☐ Female
☐ Male
☐ Gender Queer
☐ Transgender Male
☐ Transgender Female
☐ Other
☐ Don't know
☐ Choose not to disclose

Sexual Orientation
☐ Lesbian, gay, or homosexual
☐ Straight or heterosexual
☐ Bisexual
☐ Something Else
☐ Don't know
☐ Choose not to disclose

Family Financial Information

Family/Household Size: _____
Income $_____

☐ Weekly ☐ Monthly
☐ Bi-weekly ☐ Annually

Language

Primary Language:
_____

Would you like a translator for your appointment? ☐ Yes ☐ No

Work & Housing
What is your employment status?
☐ Employed
☐ Self Employed
☐ Unemployed
☐ Retired
☐ Disabled
☐ Full Time Student
☐ Part Time Student

Are you a farmworker? ☐ Yes ☐ No
If yes, what is your status?
☐ Full Time
☐ Seasonal
☐ Migrant

Are you currently homeless? ☐ Yes ☐ No

Transportation
Do you need help with transportation to your appointments? ☐ Yes ☐ No

Consent and Release:
I hereby authorize the Community Health Center of Franklin County to provide treatment as necessary for me and my family, including emergency care if necessary. I also authorize release of all necessary information to my insurance company, payer, and/or medical/dental provider for the purpose of payment or providing continuing treatment. I assign the Community Health Center of Franklin County to claim and collect insurance benefits payable for its treatment of me and my family. I understand that I may be responsible for payment of any service not covered by insurance or other benefits, including claims occurring under accident coverage such as workers compensation or automobile insurance. I understand that my insurer may require me to have a CHCFC provider designated as my PCP to have my medical visits covered.

X _____
Signature of patient or parent/legal guardian **Date**

Staff Initials: _____

Created: 4/2021 Updated: 5/2021

PERMISSION TO RELEASE PATIENT INFORMATION

We **will not** give information out to anyone unless their name(s) is written below and signed by you. This release of information does not include record requests to/from other doctor's offices, requests by insurance companies or other outside agencies. You must fill out specific releases for these purposes.

Patient Name: _____ Date of Birth: _____

1. I hereby give permission to the Community Health Center of Franklin County release the following to those listed below:

- ☐ Written prescriptions or medications
- ☐ Pick up or discuss test results or test requisitions (i.e. lab slips)
- ☐ Dental x-rays
- ☐ Discuss specialist referrals or appointments
- ☐ Verify or change my appointment at the health center
- ☐ Discuss dental treatment
- ☐ School nurse, Principal, Psychologist (school-related)
- ☐ Other: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

~ OR ~

2. I do not allow any information about me released to anyone: ☐

PLEASE SIGN BELOW

Patient/Guardian signature: _____ Date: _____

Medical & Dental Health History

Today's Date: _____

Name:_____ Date of Birth:_____

Date of last physical exam: _____ Date of last dental exam: _____

Previous Provider: _____ Previous Dentist: _____

City, State:_____ City, State:_____

Previous Pharmacy: _____

Allergies (including medication, food, and environmental) OR ☐No Known Allergies

_____

_____

Current Medications (including vitamins, supplements, and birth control) Please list name, dose, and frequency.

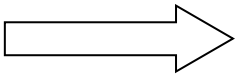
_____ _____

_____ _____

_____ _____

Please answer these questions as best you can by checking one of the following boxes, "Yes", "No", "NS" (Not Sure). Your answers are confidential and for our records only.

- Have you ever taken medications or received an IV to treat osteoporosis or bone issues (bisphosphonate drugs: Fosamax, Boniva, etc.)? ☐ Yes ☐ No ☐ NS
- Have you ever been hospitalized? ☐ Yes ☐ No ☐ NS
  - If yes, for what? _____
- Have you had surgery? ☐ Yes ☐ No ☐ NS
  - If yes, what surgery and when? _____
- When was your last tetanus shot? _____ Where? _____
- Have you had a colonoscopy? ☐ Yes ☐ No ☐ NS
  - If yes, when and where? _____
- Have you had a pap smear? ☐ Yes ☐ No ☐ NS
  - If yes, when and where? _____
- Have you ever had a mammogram? ☐ Yes ☐ No ☐ NS
  - If yes, when and where? _____
- Are you pregnant? ☐ Yes ☐ No ☐ NS
- Would you or your partner like to become pregnant in the next year? ☐ Yes ☐ No ☐ NS
- Are you currently breastfeeding? ☐ Yes ☐ No ☐ NS
- Do you or have you ever had exposure to hazardous material? ☐ Yes ☐ No ☐ NS
  - If yes, what material(s)? _____
- Do you use tobacco products or vape? ☐ Yes ☐ No ☐ NS



- If yes, what type and how often? _____
- Do you exercise? ☐ Yes ☐ No ☐ NS
  - If yes, what kind and how often? _____
- Are you on any special diet? ☐ Yes ☐ No ☐ NS
  - If yes, type? _____
- Do you see a specialist for a medical condition? ☐ Yes ☐ No ☐ NS
  - If yes, name and specialty? _____

Please check the boxes below that apply to your health history.

Heart/Blood Problems	Stomach/Intestine Problems	Mouth/Teeth Problems
☐ **NONE** ☐ Angina (chest pain) ☐ Congenital defect ☐ Endocarditis ☐ Anemia ☐ Heart attack_____(date) ☐ Heart surgery _____(date) ☐ High blood pressure ☐ Mitral valve prolapse ☐ Murmur ☐ Pacemaker ☐ Stroke: _____(date) ☐ Other:_____	☐ **NONE** ☐ Crohn's disease ☐ GERD (heartburn / acid reflux) ☐ Hepatitis: A B C ☐ Irritable bowel syndrome ☐ Jaundice ☐ Stomach ulcers ☐ Ulcerative colitis ☐ Other:_____ _____	☐ **NONE** ☐ Bleeding gums ☐ Clenching/grinding ☐ Difficulty chewing ☐ Difficulty swallowing ☐ Jaw pain ☐ Pain/Swelling ☐ Sensitivity ☐ Sores in mouth ☐ Other:_____ _____
Bone/Muscle Problems	**Endocrine Problems**	**Lung Problems**
☐ **NONE** ☐ Chronic pain ☐ Joint replacement: (which joint/when) _____ ☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ TMJ Disorder ☐ Other:_____ _____	☐ **NONE** ☐ Diabetes: TYPE 1 TYPE 2 ☐ Overactive Thyroid (hyperthyroidism) ☐ Underactive Thyroid (hypothyroidism) ☐ Other:_____ _____	☐ **NONE** ☐ Asthma ☐ COPD ☐ Cough with blood ☐ Persistent cough ☐ Shortness of breath ☐ Tuberculosis ☐ Other:_____ _____
Sexual Health History *The following questions are personal but are important in helping us give you the best care.* ☐ I have been sexually active in the past ☐ I am currently sexually active ☐ I have had more than one partner in the past year ☐ I have been forced or pressured into sexual activity	**Mental Health History** ☐ **NONE** ☐ Anxiety ☐ Bipolar disorder ☐ Depression ☐ PTSD ☐ Other:_____ _____	**Other** ☐ Glaucoma ☐ Kidney problems ☐ HIV/AIDS ☐ History of seizure ☐ Cancer (type): _____ _____ ☐ Any other condition or problem(s): _____ _____

Signature: _____ Date:_____

Reviewed By (Provider Signature):_____

Medical & Dental: 119 New Athol Rd, Orange, MA 01364
Phone: (978) 544-7800 ● Fax: (978) 544-0023

Community Health Center of Franklin County

Patient Consent for Health Information Exchange

PATIENT INFORMATION (Please Print Clearly)

Last Name	First Name	Middle Initial

Date of Birth (mm/dd/yyyy)	Medical/Dental Record Number	Phone Number

Home Address: City, State, Zip Code

PATIENT CONSENT FOR HEALTH INFORMATION EXCHANGE

By agreeing to **GIVE CONSENT** below, I hereby authorize any of the parties designated on the next page to communicate with one another about me verbally, in writing, or via electronic information exchange. Such communication may include requesting, receiving, providing, and using my medical/dental information. I understand that the purpose of communicating about me is to allow the parties to evaluate my needs, provide services to me, and coordinate my care. I further understand that I may be required to sign additional consent forms to be eligible for insurance coverage and payments or certain types of treatments and services.

I understand that my medical/dental information will include all pertinent information from my medical/dental record as described here:

- My name and other personal identifying information.
- My identity as an applicant for or recipient of healthcare services, which may include substance use disorder and/or mental health services.
- The contents of my medical/dental record, which may include:
  - Problems/diagnoses.
  - Visit/discharge/examination assessments and summaries.
  - Laboratory/x-ray tests and results.
  - Medications.
  - Procedures.
  - Family/social history.
  - Other information about my health.

- My medical/dental record may include information about the following conditions and treatment:
  - Mental health.
  - Substance use disorder.
  - Sexually transmitted diseases.
  - Pregnancies/abortions.
  - Domestic abuse.
  - Rape/sexual assault.
  - Genetic diseases, testing, and test results.
  - Mammograms.
  - Other information about my health.

I understand I have the right to exclude certain types of health information from being exchanged. I exclude the following:

_____

_____

I understand that certain federal laws, including the Health Information Portability and Accountability Act (HIPAA), allow providers and other healthcare organizations to exchange much of my health information without my consent in order to provide me with treatment, receive payment for my care, and manage and coordinate my care. I further understand that my healthcare providers are permitted or required by law to provide some of my medical/dental information without my consent to other healthcare providers, public health agencies, and law enforcement for purposes including but not limited to medical/dental emergencies, quality reporting, audits, crimes against persons and property, and certain legal orders. I understand that *Community Health Center of Franklin County* is not responsible for authorized or unauthorized re-disclosure of my health information by receiving providers.

Patient Consent for Health Information Exchange

PATIENT CONSENT FOR HEALTH INFORMATION EXCHANGE (Continued)

I understand that the following healthcare providers, including their staff, employees, and contracted entities, may provide or receive my medical/dental information for the purposes of evaluating my needs, providing services to me, and coordinating my care. I understand that only the providers who need to coordinate a particular aspect of my care will provide or receive information about that aspect of my care. ☐ **Transferring Records to CHCFC** ☐ **Transferring Records from CHCFC**

☐ List specific provider(s) / practice(s) *Attach additional sheets if needed* _____ _____ Prior PCP **(Incoming Records Only):** _____	**Records to be Disclosed:** ☐ Medical ☐ Dental ☐ Other:	**Type of Records:** ☐ Entire record ☐ Immunizations only ☐ Other:	**Period of Information:** ☐ Entire period of care

CHCFC OFFICE USE ONLY: ☐ **CHD** ☐ **BFMC** ☐ **ATH/HWH**

☐ General designation

I understand that any of my treating providers may provide or receive my medical/dental information for treatment purposes. I understand that I have a right to obtain, upon request, a list of entities to whom my medical/dental information has been disclosed (List of Disclosures), pursuant to the general designation.

☐ I give permission to share information from my medical/dental record about HIV antibody and antigen testing with:

_____ _____ _____

Print name of facility and provider *Patient Initials* *Date*

I understand that my healthcare providers may communicate my information by any means, including verbally, by paper, by fax, by secure electronic transmissions, and by the Massachusetts Health Information Highway (the Mass HIway).

MY CONSENT CHOICE

I understand that I have the right to receive a copy of this consent form.

☐ **I GIVE CONSENT**. By my signature below, I acknowledge that I have given my consent as indicated above freely, voluntarily, and without coercion. I understand that I have the right to revoke this consent at any time; however, any information that was already exchanged cannot be taken back. If I have not revoked this consent, it will expire when one of the following conditions is satisfied. Choose one:

- ☐ Consent expires one year after the **Effective Date** of this consent (below)
- ☐ Consent expires on this date:_____
- ☐ Consent expires upon this condition or event:_____

☐ **I DENY CONSENT**. By my signature below, I acknowledge that I have denied consent for my healthcare providers to communicate my health information to one another. I acknowledge that by denying my consent, my healthcare providers may have limits on their ability to provide and coordinate my care.

_____ _____

Signature of Patient **Effective Date**

_____ _____

Signature of Patient's Legal Guardian or Authorized Representative **Effective Date**

_____ _____

Print Name of Legal Guardian or Authorized Representative **Description of Authority** *if signed by Legal Guardian or Authorized Representative*

_____ _____

Signature of Translator (if applicable) **Printed Name of Translator (if applicable)**

ELECTRONIC COMMUNICATIONS AUTHORIZATION

Please review the following practices that the health center uses to communicate with you electronically. Your signing this form and providing us with your email and/or phone number, constitutes acceptance of and your acknowledgement of these communication practices. If you would rather not have us communicate using phone or text, please be sure to check the **NO** box to the right of each box.

E-Mail Address: _____ @ _____ . _____

WE WILL CONTACT YOU BY EMAIL, including but not limited to: appointment reminders, medication refills, care coordination, other Health Center publications, and messaging to support access to my secure patient chart online. I understand regular e-mail is insecure in transit over the internet, and so all e-mail communications from the Health Center to me that contain protected health information (PHI) will be encrypted unless I specifically request otherwise.	☐ NO, I do not wish to be contacted via e-mail at this time.

Text Message (SMS): (_____) _____ - _____

YOU MAY RECEIVE TEXT MESSAGES FROM US, including but not limited to: appointment reminders, medication refills, care coordination, other Health Center publications, and messaging to support access to my secure patient chart online. I understand the receipt of text messages may incur additional charges from my texting provider, and I am solely responsible for this expense. I understand text messages may be insecure in transit, and so messages from the Health Center to me will not contain protected health information (PHI), unless I specifically request otherwise.	☐ NO, I do not wish to be contacted via text message at this time.

Health Information Exchange (HIE)

WE WILL UTILIZE ALL AVAILABLE TECHNOLOGIES for the secure and efficient coordination of my care with my other health care providers and community-based organizations, including but not limited to the Massachusetts Health Information Highway (Mass HIway), Pioneer Valley Information Exchange (PVIX), electronic referrals (e-Referral), and electronic prescription history synchronization (RxHx).	☐ NO, I object to the use of secure electronic communications using HIE technologies at this time. I understand this preference limits my clinical team to the use of inefficient fax and paper records for coordination of my care with my other health care providers, including in the event of a medical emergency.

This authorization is effective as of the date indicated below. I understand I may modify these communication preferences at any time. Please allow 48 business hours for processing.

Patient Name (Print)

Signature of Patient, Parent or Guardian

Date

Relationship to Patient (if applicable)

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New Patient Policy Packet

Please sign the last page and return to CHCFC

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PATIENT POLICIES

MEDICATION REFILL POLICY

It is important to realize that you are not a patient of record until we see you for your first visit. We cannot provide any prescription refills, fill out any forms, or provide you with advice until your first appointment and often until we receive your previous medical records. **To avoid running out of medications during the time you are changing offices, be sure to get at least a two month supply of any medications you take from your current doctor before transferring your records.**

CHRONIC PAIN PHILOSOPHY

CHCFC provides treatment of chronic pain by various methods that may include medications and/or alternative treatment recommendations such as physical therapy, water therapy, massage, acupuncture, pain clinics and specialist consults. We will work with you to put together a comprehensive plan to assist you in managing your pain.

NO SHOW POLICY

A "No Show" is defined as not coming in for a scheduled appointment. Any patient with three (3) "No Shows" within a twelve (12) month period may be subject to discharge from the practice following a review of their case by their primary care provider of record. If you are having trouble keeping appointments, please let us know how we can assist you, for example if you need transportation we may be able to provide it.

RED FLAG RULES

To protect Americans from identity theft, the Federal Trade Commission recently passed laws that require us to take measures that protect our patients from identity theft. This will affect patients in several ways:

1. New adult patients will be required to provide a photo ID for their chart.
2. Established adult patients will have their photo ID verified once a year.
3. All patients with insurance must provide a copy of their card for their chart.
4. If you suspect that someone else has used your insurance information or otherwise stolen your identity, report it immediately to local police and to our Business Office.
5. We will investigate cases where possible identity theft or use of another person's insurance or other information may have been used illegally. When appropriate, we may require additional documentation to verify a person's identity. We will notify authorities in cases where we reasonably believe that identify theft, fraud, or other illegal activity has occurred.

PATIENT PAYMENT POLICIES

INSURANCE COPAYS:

Insurance copays are expected at the time of service. CHCFC will bill copays if not paid at time of service. Payment in full is expected within 30 days of receipt of the statement. If the patient has missed three consecutive copays, the patient will receive a letter from the Billing Manager stating that the patient must pay their next appointment copay and an amount on their back due copays or they must contact the business office for payment arrangements on any outstanding balance. If balances are not paid within 90 days of date of service and the patient has not made any payment agreements, the patient's account will be sent to a collection agency for collections.

PATIENT BALANCES AFTER INSURANCES:

If a patient has a balance due after billing the insurance company, the patient will receive a statement showing the amount due. Payment in full is expected within 30 days of receipt of the statement. Patients will receive a monthly statement until the account is paid in full. If balances are not paid within 90 days of date of service and the patient has not made any payment agreements, the patient's account will be sent to a collection agency for collections.

FINANCIAL ASSISTANCE:

It is the policy of CHCFC to offer payment plans to patients that are not able to pay their bills for services provided by CHCFC within 90 days from the date of service. Patients should contact the billing office at 413-325-8500 ext 150 to apply for a payment plan. The patient will be responsible for making payment arrangements as agreed to in the signed payment plan.

If you do not have insurance, please contact our outreach and enrollment department to apply for coverage. If coverage cannot be obtained through the state's enrollment system for reasons other than nonpayment of the premium, you may be eligible for a sliding fee scale based on your annual income. Annual income must be verified by CHCFC staff. Please let us know if you have any questions or feedback about our sliding fee discount schedule.

Notice of Privacy Practices (Revised 08/01/2009)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective 08/01/2009 and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records: (1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information. (2) We are required to abide by the terms of this Notice currently in effect. (3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure. We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and certification of death/investigations to determine cause of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We are required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials if you or another person is in immediate threat of danger to health or safety. In most circumstances, we must provide health information when ordered by a court of law or subpoenaed to do so. We must provide access to your health information for purposes of responding to complaints to state or federal licensing entities such as the Board of Registration in Medicine and the Department of Public Health. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such

information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning treatment by a mental health provider, drug or alcohol treatment, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization, a subpoena, or a court order.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that you completed a signed Authorization for, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to:
PRIVACY OFFICER, 102 Main Street, Greenfield MA, 01301

NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES

YOUR RIGHTS

- You have the right to receive respectful, compassionate care in a safe and non-threatening environment regardless of your age, gender, race, national origin, religion, sexual orientation, gender identity, or disabilities.
- You have a right to know the identity and professional status of all health care team members providing your care.
- You have the right to be informed about your diagnosis and prognosis, if it is known, and to be informed about the risks and benefits of all treatment options offered to you. You have the right to written informed consent prior to any non-emergency medical procedure.
- You have the right to choose a primary care provider (PCP) and to transfer your care to another PCP within the health center or to another practice.
- You have the right to confidentiality and can expect that communications and records of your care are confidential, unless disclosure is permitted or required by law.
- You have the right to inspect your medical/dental record upon request and to receive a copy of your medical/dental record. The fee will be determined by the copying expenses. You have the right to receive a list of people to whom your records have been disclosed.
- You have the right to privacy during medical treatment within the capacity of the facility.
- You have the right to request the presence of an escort during any type of examination.
- You and any family or friends you designate have the right to participate fully in decisions about your care, including the right to refuse treatment.
- You have the right to communication that you can understand, including provision of language interpretation services, if needed, at no cost to you.
- You have the right upon request, to receive information regarding opportunities for financial assistance and free health care services.
- You have the right to refuse to be examined, observed, or treated by students or any other facility staff without jeopardizing your access to medical care.
- You have the right to refuse to serve as a research subject and to refuse any care or examination when the primary purpose is educational or informational rather than therapeutic.
- You have the right to life-saving treatment in an emergency without discrimination related to economic status or source of payment and without delaying treatment for purposes of prior discussion of the source of payment, unless such delay can be imposed without material risk to your health.
- You have the right to examine and receive an explanation of your itemized bill, including 3rd party reimbursement, regardless of the source of payment.
- You have the right to voice your concerns about the care you receive. If your concern is not resolved to your satisfaction, please contact:

Chief Operations Officer
102 Main Street
Greenfield, MA 01301
or call (413) 325-8500

YOUR RESPONSIBILITIES

- You are expected to provide complete and accurate information regarding your name, date of birth, address, telephone number, and insurance carrier, when requested.
- You are expected to provide complete and accurate information about your health and medical history.
- You are expected to keep scheduled appointments, be on time, and call ahead if you cannot keep an appointment.
- You are expected to ask questions when you do not understand information or instructions. If you believe you cannot follow through with your treatment plan, you are responsible for informing your provider. You are responsible for the outcome if you do not follow the plan of care recommended by your provider.
- You are expected to treat all staff and other patients with respect and not to behave in a disruptive, disrespectful, or threatening manner.
- You are expected to provide information necessary for claim processing and to be prompt in payment of your bills.

CHCFC
Community Health Center of Franklin County

PATIENT VERIFICATION OF RECEIPT

My signature below is to verify that I was given a copy of each document listed below. I understand that I may request a new copy of these documents at any time.

- Medication Refill Policy
- Chronic Pain Philosophy
- No Show Policy
- Red Flags Rule (Identity Theft) Notice
- CHCFC Patient Payment Policy
- Notice of Privacy Practices (HIPAA Notice)
- Patient Rights Notice

I may request that these documents be mailed to me in the alternative format:

- Large Print

_____

Print Patient Name

_____

Patient/ Guardian Signature Date

Greenfield Medical & Dental
102 Main Street
Greenfield, MA 01301

Tel: (413) 325 - 8500

Urgent Dental Care
164 High Street
Greenfield, MA 01301

Tel: (413) 325 - 8700

Orange Medical & Dental
119 New Athol Rd
Orange, MA 01364

Tel: (978) 544 - 7800