Hi there,

Welcome to the Mountain Valleys Health Centers' Family

Our Mission

The mission of MVHC is to provide access to total health care services for all people, with an emphasis on preventative care and education, and with self-care and health maintenance being the end result. This will be achieved through effective program management, fully equipped medical facilities, and by the recruitment and development of highly qualified and dedicated health care professionals willing to serve the rural populations.

Services

Medical Services

- Primary Care
- Preventative Health
- Chronic Disease Management
- Physicals- CHDP, Sports, School, DMV, etc.
- Geriatric Care
- Women's Health
- Prenatal Care and Well Baby Care
- Family Planning
- Urgent Care
- Podiatry
- Minor Surgery
- Diabetic Education
- Tobacco Cessation Counseling
- Basic Laboratory Services and Blood Draws
- Diagnostic Testing
- Hearing and Vision Screening
- Immunizations
- Pediatrics

Dental Services

- Primary and Preventative Dental Care
- Emergency Visits
- Exams and X-Rays
- Oral Cancer Screening
- Standard Teeth Cleaning
- Fluoride Treatment and Sealants
- Deep Teeth Cleaning
- Fillings
- Root Canals
- Crowns
- Extractions
- Dentures and Partials

Behavioral Health Services

- Counseling
- Marriage and Couples Therapy
- Bereavement
- Child and Adolescent Therapy
- Psychological Disorders Arising from Health Problems
- Stress, Mood, and Anxiety Treatment and Management
- Psychological Assessment and Evaluation
- Addiction and Addiction Related Disorders
- Case Management
- Medication Assisted Treatment

After Hours Access

Even after regular clinic hours have ended, patients still have the ability to contact a nurse with health-related questions. MVHC offers this service through Partnership Health Plan and Team Health Medical Call Center. A patient can speak with a Registered Nurse simply by calling any MVHC phone number; easy prompts will direct your call to appropriate system.

Sliding Fee

MVHC offers sliding fee discounts to eligible patients with or without insurance. Eligibility is based on annual income and family size compared to Federal Poverty Guidelines. Anyone may apply. Please ask the front desk, we are always happy to assist you.

Let's Work as a Team

We strive to be as efficient and effective as possible with your health care. We need your help! At each clinic visit please:

- Bring all of your medication bottles, or a complete list of all medications that you take, including strength, how often you take, including over the counter medications
- If you need refills on your medications, please let us know at your appointment
- Let us know if you have had care elsewhere- specialty provider, hospital visit, emergency room diagnostic testing (lab, xray)
- Please make sure we stay up to date with your most current information- phone number, address, and insurance information

A Message from our CEO

Mountain Valleys Health Centers, Inc., is a not-for-profit community health center organization offering quality health, behavioral health, and dental care to rural communities in northeastern California for over 30 years. It is our goal to provide top-of-the-line comprehensive health care to our patients. We strive to recruit the best medical providers, dentists, and behavioral health specialists available and to provide them with quality staff. We believe the personal relationship between a patient and doctor is the key to quality care. It is our goal to treat all patients like family.

All eight of MVHC's sites are designated as Federally Qualified Health Centers (FQHC). As an FQHC, our goal is to promote wellness and education. We accomplish this through regular, comprehensive health care.

What is a not-for-profit? The very simple definition is that the company owners are not compensated. So who are the owners? They are a group of very dedicated volunteers who donate their time to serve on the board of directors. The MVHC board meets monthly to review financial operations and approve policy. Each community served by MVHC is represented by members on the board; essentially, the community owns the health centers. The board hires the CEO to oversee operations and provide day-to-daymanagement.

It is my honor to serve our rural communities in beautiful Northeastern California.

Shannon Gerig, CEO
Mountain Valleys Health Centers

Our Locations

Big Valley Health Center
Phone: (530)999-9010

Big Valley Dental Center
Phone: (530)999-9011

Burney Health Center
Phone: (530)999-9030

Burney Dental Center
Phone: (530)999-9031

Butte Valley Health Center
(530)999-9070

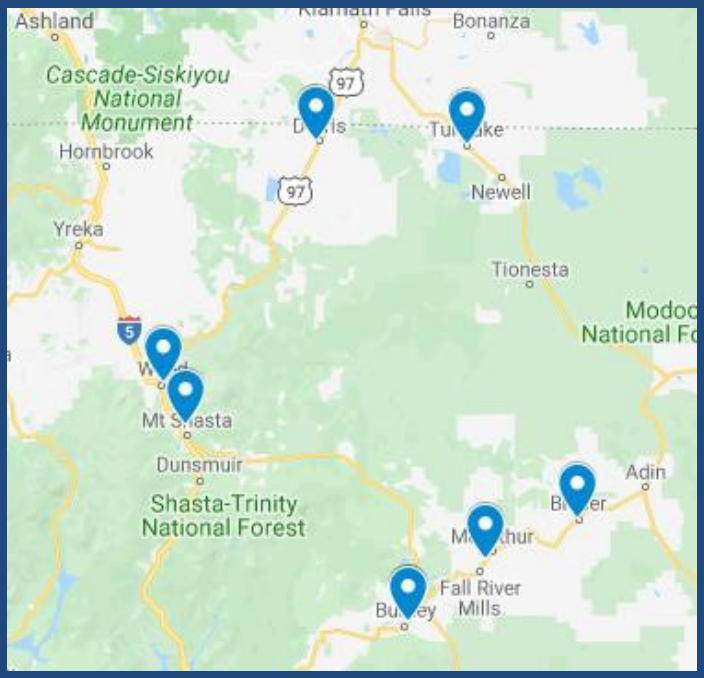
Butte Valley Dental Center
(530)999-9071

Fall River Valley Health Center
(530)999-9020

Tulelake Health Center
(530)999-9060

Mt. Shasta Health Center
(530)999-9040

Weed Health Center
(530)999-9050



Notice of Nondiscrimination

Mountain Valleys Health Centers (MVHC) complies with applicable Federal civil rights laws and does not discriminate, exclude, or treat people differently because of race, color, national origin, age, disability, or sex.

MVHC provides free aid and services to people with disabilities to communicate effectively with us such as:

- Written information in other formats (large print and electronic formats)

MVHC provides free language services to people whose primary language is not English such as:

- Interpreters
- Information written in other languages

Please request interpreter services when making your appointment.

MVHC staff, with prior notice, may translate forms and notices upon request using Google Translate https://translate.google.com/.

If you have any questions regarding the aforementioned services or if you believe that MVHC has failed to provide these service or discriminated against you on the basis of race, color, national origin, age, disability, or sex, you may file a grievance in person, by mail, or fax by contacting:

Michelle Salters CCO
P.O. Box 277
Bieber, CA 96009
Phone: (530) 999-9010
Fax: (530) 294-5392

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal,hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

The complaint form is available at http://www.hhs.gov/ocr/office/file/index.html.

Notice of Privacy Practices

Effective Date May 1, 2018

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

WHO WE ARE

This Notice describes the privacy practices of **Mountain Valleys Health Centers (MVHC)** and the privacy practices of:

- All of our doctors, nurses, and other health care professionals authorized to enter information about you into your medical record;
- All of our departments, including, our medical records and billing departments;
- All Mountain Valleys Health Center sites.
- All MVHC staff, volunteers, and other personnel who work for us or on our behalf.

OUR RESPONSIBILITIES

We understand that health information about you and the health care you receive is personal. When you receive treatment and other health care services from us, we create a record of the services that you received. We need this record to provide you with quality care and to comply with legal requirements. This notice applies to all of the records relating to your care maintained by MVHC and tells you about the ways in which we may use and disclose your protected health information (PHI) as well as your rights with respect to the health information that we keep about you.

We are required by law to:

- Make sure that health information that identifies you is kept private in accordance with relevant law;
- Give you this notice of our legal duties and privacy practices with respect to your PHI;
- Notify you if there is a breach of your PHI; and
- Follow the terms of this notice currently in effect for all of your personal health information.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

We are allowed by law to use and disclose certain PHI without your written permission. Following are some examples of these uses and disclosures.

For Treatment

We can use your PHI and disclose it to other medical professionals who are treating you. For example, a healthcare provider treating you for an injury may ask another healthcare provider about your overall health condition.

For Payment

We can use and disclose your PHI to bill and get payment from a health plan or other entities. For example, we give information about you to your health insurance plan so it will pay for your services.

For Healthcare Operations

We can use and disclose your PHI to run our business, improve your care, and contact you when necessary. For example, we can use health information about you to manage your treatment and services.

OTHER WAYS IN WHICH WE USE OR DISCLOSE YOUR HEALTH INFORMATION

We are allowed or required to disclose your PHI in other ways – including ways that contribute to the public good, such as for public health and research purposes. Following are some examples of these uses and disclosures.

Health-Related Services and Treatment Alternatives

We may use and disclose your PHI to tell you about health-related services or recommend treatment options or alternatives that may be of interest to you. Please let us know if you do not wish us to contact you with this information, or if you wish to have us use an alternate contact when sending this information.

Appointment Reminders

We may use and disclose your PHI to contact you as a reminder that you have an appointment at MVHC.

Help With Public Health and Safety Issues

We can disclose your PHI 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.

Research
We can use or disclose your PHI for health research.

As Required by Law
We will disclose 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 are complying with federal privacy law.

Organ and Tissue Donation
We can disclose your PHI to organ procurement organizations.

Coroners, Health Examiners, Funeral Directors
We can disclose your PHI to a coroner, medical examiner, or funeral director when an individual dies.

Workers' Compensation, Law Enforcement, and Other Government Requests
We can use or disclose your PHI:

- For worker's 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.

Lawsuits and Legal Actions
We can disclose your PHI in response to a court or administrative order, or in response to a subpoena.

Inmates
If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your PHI to the corrections institution or law enforcement official for certain purposes such as to protect your health and safety, the health and safety of someone else or the safety and security of the correctional institution.

YOUR CHOICES
If you have a clear preference for how we disclose your PHI in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

Disclosures in Case of Disaster Relief
We may use or disclose your PHI with a public or private entity authorized by law to assist in disaster relief efforts. Such disclosure will be made so your location and condition may be accessible to family and friends unless you object at the time.

Others Involved in Your Care
Your PHI may be disclosed when a family member or other person involved in your care is present while we are discussing your PHI unless you object.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and disclose your PHI if we believe it is in your best interest. We may also disclose your information when needed to lessen a serious and imminent threat to health or safety.

Health Information Exchange
We participate in one or more health information exchanges (HIEs). An HIE is a system that electronically moves and exchanges PHI between a group of participating health care providers. Your PHI will be available to providers authorized to use the HIE unless you notify us in writing that you do not want to participate.

Fundraising Activities
We may contact you for fundraising efforts, but you can tell us not to contact you again.

DISCLOSURES REQUIRING A WRITTEN AUTHORIZATION
We are required to receive written authorization to use or disclose your PHI in certain situations. Some examples of which include, disclosures to a life insurer for coverage purposes, a pre-employment physical or lab test, disclosures to a

pharmaceutical firm for their own marketing purposes, most uses or disclosures of psychotherapy notes, marketing communications and sales of PHI.

Other uses and disclosures of your PHI not covered by this notice or applicable law will be made only with your written authorization. If you give us your written authorization to use or disclose your personal health information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by your written authorization. You understand that we are unable to take back any uses and disclosures that we have already made with your authorization, and that we are required to retain our records of the care that we have provided to you.

YOUR RIGHTS

You have certain rights with respect to your PHI. This section of our notice describes your rights and how to exercise them.

Right to Inspect and Copy

You have the right to inspect your medical and billing records.

You have the right to request a copy of your PHI as a photo copy or in an electronic format as agreed to by you and MVHC. You may ask that your PHI be sent to a third party designated by you, provided that any such choice is clear and conspicuous. Please be aware that email across open networks is not secure and may represent a risk to you if you request a copy of your PHI in this manner.

Please be aware that your request to view or copy your medical record may be denied in certain very limited circumstances.

To inspect and/or receive a copy of your PHI you must submit your request in writing. You may be charged a reasonable cost-based fee for the expense of supplies, postage and the labor involved in fulfilling your request.

Right to Correct your Medical Record

If you feel that the PHI we maintain about you is incorrect or incomplete, you may ask us to amend the information. This request must be made in writing on a single page, hand written legibly or typed. It must fully explain the need for correction and provide a reason that supports your request.

We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to correct information that:

- Was not created by us, unless the person or organization that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for MVHC;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

After receiving your request we will review it and respond to you in writing. If approved we will make the correction or addition to your PHI. If denied you will be given the opportunity to submit a written statement limited to 250 words for each alleged incorrect or incomplete item. Your statement must clearly indicate your desire to have the statement made a part of your record. When so indicated, we will attach the statement as an addendum to your record and shall include it whenever that portion of your record is disclosed to any third party.

Right to 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 agree to all reasonable requests.

Right to Request Restrictions

You can ask us **not** to disclose certain health information for treatment, payment or healthcare operations. You can request a limit on the PHI we disclose about you to someone who is involved in your care or for the payment for your care, such as a family member or friend. In most instances 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 disclose that information to your health insurer for the purpose of paying for our operations. We will say “yes” unless a law requires us to share that information. You must notify our staff, in writing, at the time of service if you wish to exercise this right.

Right to Receive an Accounting of Disclosures

You have the right to receive an accounting of disclosures of your PHI maintained in our electronic health record.

To request an accounting of disclosures you must submit the request in writing to our privacy contact person identified on the last page of this notice and state the period of time for which you are requesting the accounting. Such time may not be more than three (3) years from the request date.

MVHC will provide one accounting of disclosures to a patient in any 12-month period free of charge. Additional requests for an accounting of disclosures within a 12-month period may be assessed a fee.

Right to a Paper Copy of this Notice

You have the right to receive a paper copy of this notice at any time. To receive a copy, please request it from our privacy contact person identified on the last page of this notice.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services: U.S. Department of Health & Human Services, 200 Independence Avenue, S. W. Washington, D.C. 20201. Phone (202) 619-0257 Toll Free (877) 696-6775.

You may file a complaint with MVHC by mailing, faxing or e-mailing a written description of your complaint or by telling us about your complaint in person or over the telephone. Please describe what happened and give us the dates and names of anyone involved. Please also let us know how to contact you so that we can respond to your complaint. You will not be penalized for filing a complaint.

MVHC's privacy contact person is:

Michelle Salters, CCO
Mountain Valleys Health Centers
P.O. Box 277
554-850 Medical Center Drive
Bieber, California 96009
Phone: 530-999-9010 Fax: 530-294-5392

CHANGES TO THIS NOTICE

We reserve the right to change this notice and to make the changed notice effective for all PHI that we maintain about you, whether it is information that we previously received about you or information we may receive about you in the future. We will post a copy of our current notice in our facility. Our notice will indicate the effective date on the first page, in the top right-hand corner. We will also give you a copy of our current notice upon request.

Please sign and date the attached Acknowledgment of Receipt and return it to the Front Desk. Please retain this Notice of Privacy practices for your records.

Patient Name:_____Date of Birth _____

About Our Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- Our obligation under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this notice
- The person to contact for further information about our privacy practices.

We are required by law to give you a copy of our Notice of Privacy Practices and to obtain your written acknowledgement.

Patient acknowledgement of receipt

I_____, hereby acknowledge that I have
(Print Name)

Received a copy of MVHC's Notice of Privacy Practices.

_____

Patient's Signature Date

_____

Signature of parent or patient representative (if applicable) Date

_____

Description of legal Authority to act on behalf of patient. Date

Current Notice became effective 5/1/2018

Mountain Valleys

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

Adolescent Patient Health Questionnaire-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Please mark your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling down, depressed, irritable, or hopeless?	0□	1□	2□	3□
2. Little interest or pleasure in doing things?	0□	1□	2□	3□
3.Trouble falling asleep, staying asleep, or sleeping too much?	0□	1□	2□	3□
4. Poor appetite, weight loss, or overeating?	0□	1□	2□	3□
5. Feeling tired or having little energy?	0□	1□	2□	3□
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down?	0□	1□	2□	3□
7. Trouble concentrating on things, such as school work, reading or watching television?	0□	1□	2□	3□
8. Moving or speaking so slowly 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?	0□	1□	2□	3□
9. Thoughts that you would be better off dead or of hurting yourself in some way?	0□	1□	2□	3□

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes? □ Yes □ No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

□ Not difficult at all □ Somewhat difficult □ Very difficult □ Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life? □ Yes □ No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? □ Yes □ No

PHQ-9 Score:_____

Adolescent Screening, Brief Intervention, and Referral to Treatment (SBIRT)

In the ***past year***, **on how many days** have you had more than a few sips of beer, wine, or any drink containing alcohol or used cannabis or other illegal drugs? _____

If your friends drink, **how many drinks** do they usually drink on an occasion? _____

Mountain Valleys

Today's Date _____

Child 0 - 11 years

Name:_____ **Birthdate:**_____ **Age:**_____

Nickname: _____ **Social Security Number (SSN):** _____

Gender: □M □F

Mailing Address: _____

(P.O. Box) City State Zip Code

Physical Address:_____ **County:** _____

Telephone - home:_____ **cell:**_____ **work:** _____

E-Mail Address:_____ **Driver's License Number**_____

Parent/Guardian #1:_____ **Birthdate:** _____

Type of Parent: □Biological □Adoptive □Foster □Other_____ **SSN:** _____

Parent/Guardian #2:_____ **Birthdate:**_____

Type of Parent: □Biological □Adoptive □Foster □Other_____ **SSN**:_____

Address and Phone if different than child's: _____

Primary Care Provider: _____ **Pharmacy:**_____

Primary Language: □English □Language other than English (specify)_____

Do you work in Agriculture? Yes □/ No□ **Are you homeless?** Yes□ / No□

Ethnicity □Not Hispanic or Latino □Hispanic or Latino

Race □American Indian/Alaska Native □Black/African American □Other Pacific Islander □Asian
□Native Hawaiian □White

Annual Family Income: □Under $15,000 □$15,000 to $24,999 □$25,000 to $34,999 □$35,000 to $49,000
□$50,000 to 74,999 □$75,000 to $100,000 □Over $100,000

Number in Family*:* _____

METHOD OF PAYMENT

□Private Insurance □Medicare □Medi-Cal □Partnership HealthPlan of California
□Private Pay □Sliding Fee □Cash □Other

INSURANCE INFORMATION

Name of Insurance Company:_____ **Birthdate Insured:** _____

Privacy Law allows MVHC to leave a phone message asking for a call back or to leave an appointment reminder. WITH YOUR PERMISSION, we can leave a detailed message about your medical or dental care such as, lab/test results, follow-up, case management, and medications. **I give MVHC permission to leave a detailed message on my: Home Phone:** Yes □/ No **Cell Phone:** Yes□ / No□ **E-mail:** Yes□ / No□. **Please initial**_____

Emergency Contact: **In case I am unable to be reached, the following person(s) may authorize medical treatment for my child. I may revoke this authorization at any time upon written notification of such**.

Name:_____ **Relationship to patient:** _____

Address:_____ **Phone:** _____

_____ □ Married □ Single □ Divorced

Signature of Parent or Guardian _____ □ Widow □ Legally Separated

MVHC complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Por favor, háganos saber cuando haga la cita que se necesita ayuda con el idioma.

注意：如果您说中文，您可以免费获得语言协助服务。 请在预约时告知我们您需要

Updated May 8, 2019

Mountain Valleys

Today's Date _____

Adolescent 12-17 years

Name:_____ **Birthdate:**_____ **Age:**_____

Nickname: _____ **Social Security Number (SSN):** _____

Gender: □ M □ F □ Choose not to disclose □ Transgender Male/Female-to-Male
□ Transgender Female/Male-to-Female □ Other

Sexual Orientation: □ Straight □ Choose not to disclose □ Lesbian or Gay □ Bisexual □ Other □ Unknown

Mailing Address: _____
(P.O. Box) City State Zip Code

Physical Address:_____ **County:** _____

Telephone - home:_____ **cell:**_____ **work:** _____

E-Mail Address:_____ **Driver's License Number**_____

Parent/Guardian #1:_____ **Birthdate:** _____

Type of Parent: □ Biological □ Adoptive □ Foster □ Other_____ **SSN:** _____

Parent/Guardian #2:_____ **Birthdate:**_____

Type of Parent: □ Biological □ Adoptive □ Foster □ Other_____ **SSN:**_____

Address and Phone if different than child's: _____

Primary Language: □ English □ Language other than English (specify)_____

Do you work in Agriculture? Yes□ / No□ **Are you homeless?** Yes□ / No□

Ethnicity □ Not Hispanic or Latino □ Hispanic or Latino

Race □ American Indian/Alaska Native □ Black/African American □ Other Pacific Islander □ Asian
□ Native Hawaiian □ White

Annual Family Income: □ Under $15,000 □ $15,000 to $24,999 □ $25,000 to $34,999 □ $35,000 to $49,000
□ $50,000 to 74,999 □ $75,000 to $100,000 □ Over $100,000

Number in Family*:* _____

METHOD OF PAYMENT

□ Private Insurance □ Medicare □ Medi-Cal □ Partnership HealthPlan of California
□ Private Pay □ Sliding Fee □ Cash □ Other

INSURANCE INFORMATION

Name of Insurance Company:_____ **Birthdate Insured:** _____

Primary Care Provider: _____ **Pharmacy:** _____

Privacy Law allows MVHC to leave a phone message asking for a call back or to leave an appointment reminder. WITH YOUR PERMISSION, we can leave a detailed message about your medical or dental care such as, lab/test results, follow-up, case management, and medications. **I give MVHC permission to leave a detailed message on my: Home Phone:** Yes □ / No□ **Cell Phone:** Yes□ / No□ **E-mail:** Yes □ / No□. **Please initial**_____

Emergency Contact: **In case I am unable to be reached, the following person(s) may authorize medical treatment for my child. I may revoke this authorization at any time upon written notification of such**.
Name:_____ **Relationship to patient:** _____

Address:_____ **Phone:** _____

_____ □Married □Single □Divorced
Signature of Parent or Guardian □Widow □Legally Separated

MVHC complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Por favor, háganos saber cuando haga la cita que se necesita ayuda con el idioma.
注意：如果您说中文，您可以免费获得语言协助服务。 请在预约时告知我们您需要

Updated May 8, 2019

Mountain Valleys
HEALTH CENTERS

Name:_____

Date of Birth: _____

Consent for Evaluation and Treatment

Mountain Valleys Health Centers (MVHC) believes the best care is given when health care providers work together. To that end MVHC provides Primary Care, Behavioral Health, and Dental services, and healthcare providers within these disciplines make referrals to each other to treat the whole patient. This care relationship is enhanced by MVHC's electronic health record which is integrated, meaning that clinical and behavioral health documentation is kept in one patient record. All access to patient records falls under HIPAA laws and patient information is used or disclosed by MVHC staff only as necessary and/or authorized.

MVHC shall observe federal and state laws with regard to uses and disclosures of protected health information (PHI) and shall provide its patients with a Notice of Privacy Practices which explains the patient's rights and MVHC's obligation with regard to PHI.

The professional staff of MVHC shall depend on statements made by the patient, patient's medical history, and other information to evaluate the patient's condition and decide on the best treatment. The evaluation and treatment of children and adolescents often requires the involvement of the parent(s) and/or other family members or patient representatives. However, in accordance with state and federal law, minors 12 and older may consent to certain treatment without parental/guardian involvement. When a minor may legally consent to a treatment or service the parent(s)/guardian(s)/representatives have no legal rights to those records of service and they remain under the control of the minor.

In treating patients, studies including x-rays, laboratory tests, EKGs, or psychological tests may be warranted. The medical provider will inform the patient or patient's representative of the patient's condition or disease and proposed treatment. Patients will have an opportunity to refuse treatment for each condition as provided by law. Health professions are not exact sciences and no guarantees are made concerning the course or effect of treatment proposed by the provider nor outcomes of treatment. Any questions about the benefits, risks, available options, or the limits of confidentiality with regard to a proposed treatment plan should be directed to the treatment staff.

There are risks involved in taking any medications and any questions about medications will be answered by the medical staff. Patient accepts the risks of taking prescribed medication and other treatment.

Some services at MVHC may involve the use of telemedicine equipment and interaction with providers who are not physically onsite. These sessions are transmitted via secure, dedicated, high-speed lines, and are not videotaped, routed through the internet, or saved in any way.

In order to conform to state regulations concerning treatment of all patients, MVHC must have this signed consent to examine and treat. This is a permanent consent that can be withdrawn at any time.

I understand that if I am a minor, under the age of 18, I may consent to certain Family Planning/Sensitive Services and within legal guidelines to Behavioral Health and Drug and Alcohol Counseling services; If I am under the age of 18 and under California law, able to make **all** healthcare decisions, or I am 18 years of age or older, I may consent for all health services. By signing this form, (parent or legal guardian signature, if required) I agree that I have read or had

this form read and/or explained to me, that I understand it and that any questions I asked have been answered. I understand that I am agreeing to be truthful in providing information.

I authorize the staff at MVHC to examine and treat me, or my child and also to perform any tests necessary for treatment. I personally accept financial responsibility for payment of these services and I agree to pay for them at the time of service unless I make prior arrangements with the financial department.

I authorize MVHC and its agents to release any medical information to my insurance company and I authorize the payment of insurance or Medicare benefits to be paid directly to MVHC. I acknowledge and accept that I may be seen by a medical or dental trainee, working under the guidance of a health care professional.

If signing as a parent/guardian or patient representative, I hereby represent and warrant that I am legally empowered and entitled to make healthcare decisions.

_____	_____
Patient's or Guardian's/Representative's Signature	Date
_____	_____
Type or Print Name	Date
_____	_____
Witness	Date

Mountain Valleys

Pediatric Health History

Name:_____Date of Birth:_____Today's Date:_____

Birth History

☐ Vaginal Delivery ☐ Cesarean Section ☐ Premature Birth- Age at Birth_____Weeks
Birth Weight_____pounds/ounces Birth Length_____inches ☐ Other Complications/Comments_____

_____

Past Medical History (check and comment on any/all that apply)

☐ Abuse/Neglect_____
☐ ADD/ADHD_____
☐ Allergies_____
☐ Anemia_____
☐ Asthma_____
☐ Autism_____
☐ Blood Disorders_____
☐ Cancer_____
☐ Cerebral Palsy_____
☐ Chickenpox_____
☐ Concussion_____
☐ Congenital Heart Disease _____
☐ Congenital Malformations_____
☐ Constipation_____
☐ Croup_____
☐ Cystic Fibrosis_____
☐ Developmental Delay_____
☐ Diabetes_____
☐ Eczema_____
☐ Enuresis (Bed Wetting)_____
☐ Esophageal Reflux (Heartburn)_____
☐ Eyesight Problems_____
☐ Fractures_____
☐ Headaches_____
☐ Hearing Loss_____
☐ Heart Disease_____
☐ Hyperlipidemia (High Cholesterol)_____
☐ Hypertension (High Blood Pressure)_____
☐ Immune Disorder_____
☐ Influenza (Flu)_____
☐ Jaundice_____
☐ Kidney Disease_____
☐ Liver, Stomach, or Bowel Disease_____
☐ Lung Disease_____
☐ Measles_____
☐ Mental Illness_____
☐ Muscular Dystrophy_____
☐ Otitis Media (Ear Infection)_____
☐ Pneumonia_____
☐ Pulmonary Embolism_____
☐ Scoliosis_____
☐ Seizure Disorder_____
☐ Sickle Cell_____
☐ Skin Problems_____
☐ Sleep Apnea_____
☐ Speech Disabilities_____
☐ Spina Bifida_____
☐ Thyroid Disease_____
☐ Tonsillitis_____
☐ Tuberculosis_____
☐ Urinary Tract Infection (UTI)_____
☐ Urticaria (Hives)_____
☐ Other_____

_____

_____

_____

Name:_____

Surgical History (check and comment on any/all that apply)

☐ Ear Surgery _____
☐ Nose Surgery _____
☐ Throat Surgery_____
☐ Adenoidectomy (Adenoids)_____
☐ Tonsillectomy_____
☐ Thyroid Surgery_____
☐ Cardiac (Heart) Surgery_____
☐ Lung Surgery_____
☐ Abdominal Surgery_____
☐ Appendectomy (Appendix)_____
☐ Cholecystectomy (Gallbladder)_____
☐ Hernia_____
☐ Skin/Dermal Surgery_____
☐ Orthopedic Surgery_____
☐ Bladder Surgery_____
☐ Kidney Surgery_____
☐ Bowel Surgery_____
☐ Other Surgery_____

_____

_____

Social History

Living Situation

☐ Living with Parents ☐ Living with Relatives (other than Parents) ☐ Living with Grandparents
☐ Other living arrangements_____

Siblings

☐ Brother(s)- How many?_____ ☐ Sister(s)- How many?_____

Substance Use/Exposure

☐ Exposed to cigarette and/or marijuana smoke at home?_____
☐ Alcohol ☐ Cigarettes ☐ Cocaine/Methamphetamine ☐ Marijuana
☐ Other _____

Activities/Exercise

☐ Baseball ☐ Bicycling ☐ Basketball
☐ Fishing ☐ Cheerleading ☐ Hiking
☐ Football ☐ Hunting ☐ Golf
☐ Running ☐ Gymnastics ☐ Skateboarding
☐ Soccer ☐ Skiing ☐ Softball
☐ Walking ☐ Swimming ☐ Wrestling
☐ Track and Field ☐ Volleyball
☐ Other Activities_____

Name:_____

Family History (check all that apply)

	MOTHER	FATHER	BROTHER	SISTER	GRANDPARENT
Alcoholism					
Anemia					
Asthma					
Autoimmune Disease					
Birth Defects					
Blood Disorders					
Cancer					
Crohn's Disease					
Cystic Fibrosis					
Diabetes Mellitus					
Hearing Loss					
Heart Disease					
High Cholesterol					
High Blood Pressure					
Infectious Disease					
Kidney Disease					
Lupus					
Mental Health Issues					
Migraine Headache					
Other					
Sickle Cell Abnormality					
Stroke					
Thyroid Disorders					
Tuberculosis					
Ulcerative Colitis					

Additional Comments

Mountain Valleys

MINOR CONSENT FORM

Child Name:_____**Date of Birth:** _____

The above-named patient is a minor child. Should I or another legal guardian be unavailable the following person (s) has/have my permission to consent to treatment for the child in my behalf. This authorization shall be in force until revoked by me in writing or the child reaches the age of majority.

Name:_____**Relationship to Patient:** _____

Name:_____**Relationship to Patient:** _____

_____

Parent / Legal Guardian Signature **Date**

Consentimiento para Menor de Edad

Nombre de Niño(a)_____***Fecha de Nacimiento***:_____

El paciente antes mencionado es un menor de edad. Si yo o algun otro guardian legal no esta disponible, la siguiente persona tiene mi permiso para dar su consentimiento al tratamiento para el niño/a en mi nombre. Esta autorización estará en efecto hasta que sea revocada por mí por escrito, o que el niño/a alcance la edad mayor de dieciocho años.

Nombre:_____***Relación al paciente:*** _____

Nombre:_____***Relación al paciente:*** _____

_____

Firma del Padre / Guardián del Paciente ***Fecha***

Revised 2/18/2015

Mountain Valleys Health Centers

Sliding Fee Discount Program Policy Statements

- Patients shall receive and acknowledge receipt of MVHC's Sliding Fee Discount Program Policy.
- The Sliding Fee Discount Program shall be offered to all MVHC patients with or without insurance.
- MVHC must gather personal information in order to give a discount on medical/dental services. This information will be held in strict confidence.
- All income must be reported and used to determine eligibility for the Program. Changes to income or family size are required to be reported to MVHC.
- Patients must verify income and family size every twelve months.
- Following are some examples of documents that show proof of income:

* W-2 form	* Tax Return (required for self-employed earnings)
* Pay Stubs (2)	* Social Security/SSI benefit statement letter
* 1099G (Unemployment benefits)	* Bank statement (showing direct deposit by name)
* Letter from an employer	* Unemployment Stub

- **Patients declining to be assessed for eligibility in the Sliding Fee Discount Program by refusing to provide the required information are not eligible for the Sliding Fee Discount Program.**
- Patients unable to provide proof of income because no reasonable option for providing it exists, must complete a *Self-Declaration of Income Statement* to be approved by the Site Manager or the COO.
- Patients have 30 days from the date of service to submit a completed application with proof of income. Until required documents have been submitted and eligibility has been determined the patient is responsible for full fees. If the patient applies at a later time, **eligibility is not retroactive.**
- Payment is expected at time of service. Please note that payment in full at time of service will qualify for an additional discount - 10% for dental/medical, 15% for 65 and over **dental only**.

Please acknowledge receipt of this policy by signature designated on the Sliding Fee Discount Program Application. Please retain this Policy for your records.

Sliding Fee Discount Program Application

Name:	Date of Birth

Do you have any type of insurance that will cover all or a portion of your medical expense? Yes____No____If yes, please list below:

Definition of Family Size: "Family size" shall be determined by considering, as a group, any related or nonrelated individuals living together whose production of income and consumption of goods are co-mingled. In addition, a single individual living alone shall be counted as one person for "family size" for purposes of the sliding fee. Please answer the following based on this definition of family size.

Family size: _____

***Besides Yourself,* Give Name and Date of Birth for all individuals included in the family size. Please indicate if they are a current patient by circling yes or no.**

Name	Date of Birth	Current Patient
		Yes□ or No□
		Yes□ or No□
		Yes□ or No□
		Yes□ or No□
		Yes□ or No□
		Yes□ or No□

How often do you get paid? ☐ Weekly ☐ Bi-Weekly ☐ Twice Monthly ☐ Monthly

Definition of Income: Income is the total amount of annual money income each individual received before payments for income taxes, social security, Medicare deductions, etc. Please answer the following based on this definition of income.

For *Everyone* in your household, please list the gross income (before taxes) based on the aforementioned definition of income.

Wages:	**Public Assistance:**
Social Security/SSI:	**Rental Income:**
Unemployment:	**Interest Income:**
Disability/Workers Comp.:	**Education Assistance:**
Retirement/Pension:	**Child Support, Alimony:**
Self-Employment (Tax Return Required):	**Other (specify):**

- I acknowledge that I received and understand the MVHC Sliding Fee Discount Program Policy.
- I declare the above information is true and correct. I understand that this information will be kept in strict confidence. I understand if my income or "family size" should change, I am required to notify MVHC on my next visit to the health center. I understand that giving false information will result in the denial of discount benefits and that I will be responsible for the full fee and no longer eligible for the Sliding Fee Discount Program.

Applicant's Signature:_____ Date: _____

For Office Use Only

Application received by:_____ Date:_____ Reviewed by:_____ Date_____

Supervisor Approval (for Self-Declaration) _____

Notice of Nondiscrimination

MVHC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Translation Services

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Por favor, háganos saber cuándo haga la cita que se necesita ayuda con el idioma.

注意：如果您说中文，您可以免费获得语言协助服务。 请在预约时告知我们您需要语言协

Mountain Valleys

Self-Declaration of Income Statement

Name:____**DOB:** __________________________

I am unable to provide proof of income and must self-declare my income by completing this form. I understand that I must report any income I received during the twelve months prior to the date of this declaration.

Sources and amounts of income listed in the application for which I have no proof:

Source:_______________________________________ **Amount for the last 12 months:** ____________

Reason I cannot provide proof:

____

____

Source:_______________________________________ **Amount for the last 12 months:** ____________

Reason I cannot provide proof:

____

____

Source:_______________________________________ **Amount for the last 12 months:** ____________

Reason I cannot provide proof:

____

____

Source:_______________________________________ **Amount for the last 12 months:** ____________

Reason I cannot provide proof:

____

____

If you declared zero income, please explain your current living situation and how your monthly expenses are met.

____

____

____

I declare the above information is true and correct. I understand that this information will be kept in strict confidence. I also understand that if my income or “family size” should change, I am required to notify MVHC on my next visit to the health center. I understand that giving false information will result in the denial of discount benefits and that I will be responsible for the full fee and no longer eligible for the Sliding Fee Discount Program.

Patient Signature____**Date** ____________

Self-Declared income must be approved by the Team Lead, COO or Billing Manager (signature acknowledging approval is required on the Sliding Fee Application).