Mountain Valleys HEALTH CENTERS

Big Valley Health Center
P.O. Box 277
554-850 Medical Center Drive
Bieber, CA 96009
(530) 999-9010
Fax (530) 294-5392

Burney Health Center
37491 Enterprise Drive
Burney, CA 96013
(530) 999-9030
Fax (530) 335-3060

Burney Dental Center
20615 Commerce Way
Burney, CA 96013
(530) 999-9031
Fax (530) 335-5558

Butte Valley Health Center
P.O. Box 170
610 West 3rd Street
Dorris, CA 96023
(530) 999-9070
Fax (530) 397-4567

Fall River Valley Health Center
P.O. Box 490
43658 Hwy. 299E
Fall River Mills, CA 96028
(530) 999-9020
Fax (530) 335-5166

Mount Shasta Health Center
101 Old McCloud Rd.
Mount Shasta, CA 96067
(530) 999-9040
Fax (530) 926-1859

Tulelake Health Center
P.O. Box 725
498 Main Street
Tulelake, CA 96134
(530) 999-9060
Fax (530) 667-2562

Weed Health Center
50 Alamo Ave.
Weed, CA 96094
(530) 999-9050
Fax (530) 938-2662

Dear College of the Siskiyous' Student:

Mountain Valleys Health Centers (MVHC) welcomes you! We are proud to partner with College of the Siskiyous (COS) to provide for your healthcare needs through the COS Student Health Program.

To get you started, you will be given a new patient packet. You can pick it up at the college, at one of our health centers, or on our website **www.mountainvalleys.org** under "Patient Resources." ***You must bring this completed packet and your Student ID to your first appointment, or email it prior to your appointment to wdfrontoffice@mtnvalleyhc.org*** We cannot see you without it. Please note that email is not a secure form of communication, and you assume all risk by choosing to communicate through email.

We offer a variety of services, here are some of them:

MEDICAL SERVICES

- Primary and preventive health care
- STDs, Birth Control, UTI
- Immunizations
- Basic lab services and blood draws
- Physicals – CHDP, Sports, DMV
- Tobacco cessation

BEHAVIORAL MEDICINE SERVICES

- Counseling
- Addiction and related disorders
- Behavioral Disorders
- Tourette's syndrome
- Stress, Anxiety, Depression Treatment

TELEHEALTH SERVICES

Please call our office if you wish to schedule a telemedicine (video) visit with one of our medical or behavioral health providers. You must complete and submit your new patient packet prior to your visit. **You can use a tablet, smartphone, or any device that has video capabilities.**

Check out our service sites listed in the left-hand margin and contact the health center of your choice to make an appointment. Tell the Appointment Coordinator you are a Student at COS.

Best wishes,

Shannon Gerig

Shannon Gerig, Chief Executive Officer
And the MVHC Care Team

Stay connected

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 photocopy 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, handwritten 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.

Mountain Valleys
HEALTH CENTERS

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 Mountain Valleys Health Centers (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

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

Adult Patient Health Questionnaire-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Please circle your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0□	1□	2□	3□
2. Feeling down, depressed, or hopeless	0□	1□	2□	3□
3. Trouble falling or staying asleep, or sleeping too much	0□	1□	2□	3□
4. Feeling tired or having little energy	0□	1□	2□	3□
5. Poor appetite or overeating	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 reading the newspaper 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

(SBIRT) PHQ-9 Score:_____

If you checked off any problems, 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**
□	□	□	□

ADULT SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT

1. Used tobacco products in the past 3 months? **□Yes** **□No**

2. In the past 3 months, how often do you have a drink containing alcohol?
□Never **□Monthly or less** **□2-4 times a month** **□2-3 times a week** **□4 or more times a week**

3. In the past 3 months, how many drinks containing alcohol do you have on a typical day when you are drinking?
□1 or 2 **□3 or 4** **□5 or 6** **□7 to 9** **□10 or more**

4. In the past 3 months, how often do you have 4 or more drinks on one occasion (males 65 and older and females)?
□Never **□Less than monthly** **□Monthly** **□Weekly** **□Daily/Almost daily**

5. In the last twelve months, did you smoke pot, use another street drug, or use a prescription painkiller, stimulant, or sedative for a non-medical reason? **□Yes** **□ No**

TO BE FILLED OUT BY MOUNTAIN VALLEYS' STAFF ONLY

Follow-Up Plan: (CQM-2; UDS-6B21)

Assessment	Support Staff	Provider
0 ○ {3351F} Negative For Symptoms ☐ Y **1-4** ○ {3352F} No Significant Symptoms ☐ Y	○ Advised to repeat in 1 yr or as per PCP ☐ Y	○ Advised to repeat in 1 yr or as needed ☐ Y ○ Symptoms due to acute stress/situation, advised to reassess in 3 month ☐ Y
5-14 ○ {3353F} Mild to Moderate Symptoms ☐ Y	○ Referral To Physician ☐ Y {Z71.89} Depression handout provided ○ E ☐ Y ○ S ☐ Y	○ Referred to Mental Health Worker ☐ Y Request Consultation By: ○ Mental Health Counselor ☐ Y ○ Psychologist ☐ Y ○ Psychiatrist ☐ Y ○ Child Psychiatrist ☐ Y ○ Psychiatrist- Same Day Appointment ☐ Y ○ Psychiatrist- Next Day Appointment ☐ Y ○ Psychiatrist- Next Available Appointment ☐ Y ○ Assess Suicide Risk ☐ Y Risk Management: ○ Under care of mental health team ☐ Y ○ Refusing treatment/Suicide Risk Discussed ☐ Y ○ Results discussed with Patient follow up plan initiated ☐ Y
15-27 ○ {3354F} Clinically Significant Symptoms ☐ Y	○ Request Consultation By Mental Health Counselor ☐ Y	○ Referred to Mental Health Worker ☐ Y Request Consultation By: ○ Mental Health Counselor ☐ Y ○ Psychologist ☐ Y ○ Psychiatrist ☐ Y ○ Child Psychiatrist ☐ Y ○ Psychiatrist- Same Day Appointment ☐ Y ○ Psychiatrist- Next Day Appointment ☐ Y ○ Psychiatrist- Next Available Appointment ☐ Y ○ Assess Suicide Risk ☐ Y Risk Management: ○ Under care of mental health team ☐ Y ○ Refusing treatment/Suicide Risk Discussed ☐ Y ○ Results discussed with Patient follow up plan initiated ☐ Y

MOUNTAIN VALLEYS HEALTH CENTERS

HEALTH HISTORY

Name:_____DOB:_____Today's Date:_____

Please check and comment on all that apply. Any additional detail is helpful- year, right/left, etc.

Past or Current Medical History

- □ Allergies_____
- □ Anxiety_____
- □ Arthritis_____
- □ Arthritis, Rheumatoid_____
- □ Asthma _____
- □ Atrial Fibrillation_____
- □ Anemia_____
- □ Bleeding Disorders_____
- □ Bladder Problems_____
- □ Coronary Artery Disease_____
- □ Chronic Obstructive Pulmonary Disease (COPD)

_____

- □ Cancer_____
- □ Congestive Heart Failure (CHF)_____
- □ Diabetes_____
- □ Depression_____
- □ Eyesight Problems_____
- □ Gallbladder Disease_____
- □ Gastric Ulcer_____
- □ GERD_____
- □ Gout_____
- □ Hearing Loss_____
- □ Hepatitis_____
- □ HIV Infection_____
- □ Hyperlipidemia (High Cholesterol)_____
- □ Hypertension (High Blood Pressure)_____
- □ Hypothyroidism_____
- □ Insomnia_____
- □ Low Back Pain_____
- □ Migraine Headaches_____
- □ Obesity_____
- □ Osteoarthritis_____
- □ Osteoporosis_____
- □ Peripheral Vascular Disease_____
- □ Psychiatric Disorders_____
- □ Seizure Disorders_____
- □ Sleep Apnea_____
- □ Venereal Diseases_____
- □ Number of Pregnancies_____
- □ Number of Children_____

Other Disorders or Diagnosis that you have been given by any doctor_____

_____

Surgical History

Eye Ear Nose Throat

- □ Cataract_____
- □ Thyroid Surgery_____
- □ Tonsillectomy_____
- □ Adenoidectomy_____
- □ Ear Surgery_____

Cardiovascular Surgery

- □ Aortic Aneurysm_____
- □ Angioplasty_____
- □ CABG_____
- □ HeartValve_____
- □ Cardiac Stent_____
- □ Vascular Surgery_____

Breast **Surgery**

- □ Mastectomy_____
- □ Lumpectomy_____
- □ Augmentation _____

Gastrointestinal Surgery

- □ Abdominal Surgery_____
- □ Appendectomy_____
- □ Cholecystectomy (gallbladder removal)_____
- □ Gastric Surgery_____
- □ Hernia Repair_____
- □ Ulcer Surgery_____
- □ Laparoscopy_____
- □ Pancreatic Surgery_____

Skin Surgery_____

Orthopedic Surgery

- □ Joint Surgery_____
- □ Carpal Tunnel_____
- □ Back Surgery_____
- □ Other_____

_____

GYN/GU Surgeries

- □ Cesarean (C-section)_____
- □ Hysterectomy_____
- □ Tubal Ligation_____
- □ Vasectomy_____
- □ Bladder Surgery_____
- □ Prostate Surgery_____
- □ Kidney Surgery _____

Mountain Valleys
HEALTH CENTERS

MOUNTAIN VALLEYS HEALTH CENTERS

Health History Continued

Name: _____

ER or Urgent Care (Recent) _____**Previous Hospitalizations**_____
*(Please list details, such as, reason, year, facility, etc.)*_____
_____

Social History:

Alcohol: Type_____How much/often?_____

Caffeine: Type_____How much/often?_____

Tobacco: Type_____How much/often?_____

Street Drugs: Type___How often?_____

Exercise: Type_____How much/often?_____

Special Dietary Needs:_____

Work History: Type of Work_____

Full Time, Part Time, Retired, Disabled

Family History:

Mother: Age:_____ *Living□ or Deceased□*
*If deceased, cause of death:*_____*Any History of: Diabetes□, Stroke□, Heart Attack□, High Blood Pressure□, Cancer□, Other*: _____

Father: Age: _____*Living□ or Deceased□*
If deceased, cause of death: _____ *Any History of: Diabetes□, Stroke□, Heart Attack□, High Blood Pressure□, Cancer□, Other*: _____

Brother(s): Age: _____*Living□ or Deceased□*
If deceased, cause of death: _____ *Any History of: Diabetes□, Stroke□, Heart Attack□, High Blood Pressure, □ Cancer□, Other*: _____

Sister(s): Age: _____*Living□ or Deceased□*
If deceased, cause of death: _____ *Any History of: Diabetes□, Stroke□, Heart Attack□, High Blood Pressure□, Cancer□*
Other: _____

Other Pertinent Family History: _____

List Routine Care by Other Doctors/Specialists/Hospitals:

_____

Recent Health Maintenance:

□Pap Smear:	Year _____	Results_____
□Mammogram	Year _____	Results_____
□Colonoscopy	Year _____	Results_____
□Cholesterol Screen	Year _____	Results_____
□Pneumonia Shot	Year _____	
□Tetanus: Tdap, Td	Year _____	

Mountain Valleys
HEALTH CENTERS

MOUNTAIN VALLEYS HEALTH CENTERS REVIEW OF SYSTEMS

Name:_____ **Date of Birth:**_____ **Today's Date:**_____

1. **Constitutional**
   - □ weight gain
   - □ weight loss
   - □ inadequate sleep
   - □ unusual fever
   - □ fatigue
2. **Ophthalmologic**
   - □ eye pain
   - □ redness
   - □ dryness
   - □ drainage
3. **Ear/Nose/Throat**
   - □ ear pain (otalgia)
   - □ ringing ears (tinnitus)
   - □ decreased hearing
   - □ nasal discharge
   - □ hoarseness
   - □ trouble swallowing (dysphagia)
   - □ dizziness (vertigo)
4. **Cardiovascular**
   - □ chest pain
   - □ ankle swelling (edema)
   - □ irregular heart beat (palpitations)
   - □ calf pain while walking (claudication)
   - □ inability to lie flat in bed at night (orthopnea)
   - □ waking suddenly at night to catch your breath (paroxysmal nocturnal dyspnea-PND)
5. **Respiratory**
   - □ chronic cough
   - □ coughing up blood (hemoptysis)
   - □ shortness of breath
   - □ wheezing
6. **Gastrointestinal**
   - □ nausea
   - □ vomiting
   - □ diarrhea
   - □ constipation
   - □ abdominal bloating
   - □ heartburn
   - □ blood in stools (hematochezia)
7. **Skin**
   - □ rash
   - □ unusual "moles"
8. **Women Genitourinary/ Breast**
   - □ painful or frequent urination
   - □ blood in urine (hematuria)
   - □ inability to control urination (incontinence)
   - □ pelvic pain, pain with intercourse (dyspareunia)
   - □ unusual vaginal bleeding or discharge
   - □ breast lumps
   - □ unusual nipple discharge
9. **Men Genitourinary**
   - □ bulge in groin
   - □ decreased urine stream
   - □ dribbling, or getting up to urinate at night (nocturia)
   - □ impaired erections
   - □ blood in urine (hematuria)
10. **Neurologic**
    - □ headache
    - □ weakness on one side
    - □ numbness involving face/arms/legs
    - □ slurred speech
    - □ blackout spells (syncope)
    - □ sensation of a curtain being pulled over one eye (amaurosis fugax)
    - □ double vision (diplopia)
    - □ difficultly with balance (ataxia)
    - □ memory loss or lapse
11. **Hematologic/ Lymphatic**
    - □ lumps in neck/armpits/groin
    - □ unusual bleeding or bruising
12. **Psychiatric**
    - □ hearing voices
    - □ seeing things that are really not there
    - □ feeling nervous or "jittery" (anxious)
    - □ feeling sad or worthless (depressed)
13. **Musculoskeletal**
    - □ back pain
    - □ neck pain
    - □ joint pain
    - □ joint swelling
    - □ muscle weakness
    - □ pain

Tuberculosis (TB) Risk Assessment Questionnaire

Have you experienced any of the following symptoms:	Yes	No
1. A productive, prolonged cough		
2. Coughing up blood		
3. An unexplained, persistent fever		
4. Unexplained, excessive fatigue		
5. Unexplained weight loss		
6. Have you had a tuberculin skin test within the last 6 to 12 months		
- If your test was positive, were you treated		
7. Have you ever traveled outside the United States? If so, where?_____		

Mountain Valleys HEALTH CENTERS

Today's Date _____

Adult

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** _____

Employment: □Fulltime □Part-time □None **Employer:**_____ **Phone:**_____

Marital Status: □Married □Single □Divorced □Widow □Legally Separated

Spouse's Name:_____ **Spouse's Date of Birth:**_____

Spouse's SSN:_____ **Employer:**_____

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

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

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

Ethnicity □Hispanic or Latino □Not Hispanic or Latino

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

Do you have an Advanced Directive? Yes□ / No□ **May we have a copy?** Yes□ / No□ / Not Applicable□

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

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

Address:_____ **Phone:** _____

_____ □Married □Single □Divorced
Signature of Patient or Patient Representative □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

Mountain Valleys
HEALTH CENTERS

Authorization to Discuss Patient Information

Patient Name: _____

Date of Birth: _____

I authorize Mountain Valleys Health Centers Staff to discuss: (check all that apply)

- □ Medical Information
- □ Financial Information
- □ Behavioral Health Information
- □ Dental Information

With:

Name: _____

Relationship to Patient: _____

Phone Number: _____

Name: _____

Relationship to Patient: _____

Phone Number: _____

Name: _____

Relationship to Patient: _____

Phone Number: _____

This authorization will remain in effect until revoked by me in writing.

_____

Patient or Parent/Legal Guardian Signature **Date**

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

_____ _____

Witness Date