Sierra Family Health Center
CARING FOR YOU AS FAMILY

Welcome to Sierra Family Health Center. We're very happy that you have chosen us for your health care. Our mission is to provide comprehensive, compassionate, and quality medical, dental, and behavioral health care to everyone. We strive to be a center of healing, learning, and caring, and are committed to quality and to adding value in every aspect of our work. We are a nonprofit community health center with locations at:

On the San Juan Ridge
15301 Tyler Foote Road, Nevada City | 530.292.3478
Monday-Friday 8:30 a.m. to 5:00 p.m.
Saturdays 10 a.m. to 1 p.m.

In Oregon House
8676 Marysville Road, Oregon House| 530.692.9073
Monday, Tuesday and Thursday, 8:30 a.m. to 5:00 p.m.

We accept Medi-Cal, Medicare, most private/commercial insurance, and offer a sliding fee discount for those who qualify. Please see our Financial Policy Information sheet for more details.

If you do not have insurance, please ask for a Patient Advocate to help you determine if there is insurance for which you might be eligible.

We ask that you arrive 15 minutes prior to your scheduled appointment to check in and address any needed paperwork.

Sierra Family is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen. To notify us of any changes or cancellations, please call us at (530) 292-3478 as soon as you can, but no later than 2:00 p.m. on the day prior to your scheduled appointment. To cancel a Monday appointment, please call our office by 2:00 p.m. on Friday.

We look forward to you becoming part of Sierra Family!

Grateful Patient Testimonials

"I have been a patient for over 23 years, and the wonderful staff have been a blessing for me, especially in the last few years. I've been through some tough times, and they have been concerned about me, emotionally and medically."

"I always had bad experiences with dentists until coming here. You removed all my dental fears with your kind and gentle care."

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PATIENT REGISTRATION

Please provide us with your insurance card and valid ID

Last Name________________________________ First Name___________________________ MI_____

Date of Birth__________________ Social Security# _____-____-_____ Gender at Birth ___ Male ___Female

Mailing Address____ City________________________

State___________ Zip Code__________________ Email Address__________________________________

Physical Address (if different) ____

City____ State________ Zip Code___________________

Phone: Home ______________________ Cell ______________________ Work___________________

Primary Phone: ___Home ___Cell ___Work Preferred Method of Contact: ___Call ___Text ___Email

Preferred Time of Contact: ___AM ___PM ___Evening ___No Preference

Length of Message: ___Brief ___Extended On Which Phone? ___Home ___Cell ___Work

Preferred Language: ___ English ___Other: _______________ Interpreter Needed? ___Yes ___No

Would you like access to your medical provider team & (limited) medical records online? ___Yes ___No

➪ *If yes, please see Your Patient Portal information sheet included in this packet.*

Which pharmacy do you use? ➪ *Please see our Preferred Pharmacy information included in this packet.*

Pharmacy Name ____ City ____________________

Parent Information If Patient Is Under 18

Parent/Legal Guardian ____Birthdate_______________

Contact Phone__________________________________ Email:___________________________________

Type of Parent(s): ____Biological ____Adoptive ____Foster ____Other ____________________________

Parent/Legal Guardian ____Birthdate_______________

Contact Phone__________________________________ Email:___________________________________

Type of Parent(s): ____Biological ____Adoptive ____Foster ____Other ____________________________

Emergency Contact

Let us know whom to call if there is an emergency. Please also add to the HIPAA authorization form.

Name____Relationship_______________

Phone: Home ______________________ Cell _____________________ Work ____________________

Financial and Insurance Information

Here we need the details about the account holder (the person who will be paying for services).

____Medicare ___Medicare Part D? Plan Name: ______________________________________

____Medi-Cal (type): ___ Straight Medi-Cal ___ Anthem Blue Cross ___ California Health & Wellness

____Commercial (type): ____________________

____Self-Pay

Patients may be eligible to receive a discount through the Sliding Fee Discount program. Discounts are based on family size and household income. Our staff can help you with questions regarding our health care and dental plans.

Account Holder or Person Paying the Bill

Co-pays and outstanding balances are due at the time of service. Your insurance is billed after the visit. Sometimes there is still money owed. Who should we send statements to?

____Patient ____Other

If you marked Other, please let us know:

Last Name ______________________________ First Name ____________________ MI _____

Relationship to Patient ____

Address ____ City _________________________

State __________ Zip Code ____________ Email Address: ____________________________

Phone: Home ____________________ Cell ____________________ Work ____________________

CONSENTS

In order to provide treatment, coordination of clinical care, to bill your insurance, or to release information required by your insurance carrier, you must give your consent by initialing the areas indicated, and by providing your signature below.

____(initials) Consent for Treatment: I hereby authorize and consent to procedures necessary for diagnosis and treatment for myself (or child/dependent stated above) while a patient at the Sierra Family Health Center.

____(initials) Consent for Release of Medication History: I give my permission to allow SFHC to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

____(initials) Release of Information: I authorize the release of information collected by the Center necessary for coordination of clinical care and to process billing claims related to my care (or child/dependent stated above).

____(initials) Assignment of Benefits: I authorize payment of medical benefits to Sierra Family Health Center for professional services rendered.

Your signature below indicates you have read, understand and agree to the payment policy, and consents.

Signature: ____ Date: ________________

Printed Name: ______________________________________ Relationship to Patient: ____________

Additional Information – For Purposes of Grant Funding

The information you provide can help us recognize patients who may qualify for specially funded programs or services.

Marital Status

- ☐ Single
- ☐ Married
- ☐ Partner
- ☐ Widowed
- ☐ Divorced
- ☐ Legally Separated
- ☐ Other: ______________________

Sexual Orientation (for Patients Age 18 and Up)

- ☐ Heterosexual (Straight, not Lesbian or Gay)
- ☐ Choose to Not Disclose
- ☐ Something Else: ________ ______________________
- ☐ Homosexual or Bisexual (Lesbian or Gay)
- ☐ Do Not Know

Gender You Identify With

- ☐ Female
- ☐ Transgender Male (Female to Male, Transition Date __________)
- ☐ Gender queer, not exclusively male or female
- ☐ Male
- ☐ Transgender Female (Male to Female, Transition Date __________)
- ☐ Additional gender category or other, please specify: ______________________
- ☐ Choose to Not Disclose

Race *(please check all that apply)*

- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Decline to Specify
- ☐ Other: ____

Ethnicity

- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Latino
- ☐ Decline to Specify

Other Questions

Have you served in the military? ☐ Yes ☐ No

In the last 2 years, have your or a member of your family lived away from home in order to work in any type of agricultural or farm work? ☐ Yes ☐ No

Total number of people living in household: __________

Approximate total yearly income earned by family household: $__________

Would you consider yourself homeless at any time in the last 12 months? ☐ Yes ☐ No

If yes, where? ☐ In your car ☐ With another family ☐ On the street ☐ In a hotel ☐ In a shelter ☐ Other: __________

Where did you hear about our services?

☐ Family Member ☐ Newspaper/Magazine ☐ Radio ☐ Social Media
☐ Friend who loves the service! ☐ Insurance Company ☐ Flier ☐ County Agency

YOUR PRIVACY OPTIONS

Receipt of Notice of Privacy Practices & HIPAA Authorization

This form is to help us know whether you would like us to share information with the people in your life. Telling SFHC how you want to share information is called HIPAA Authorization and it's from the Health Insurance Portability and Accountability Act (HIPAA). This form also helps us to know that we have asked to give you our privacy practices. You are welcome to have a copy of our privacy practices.

Patient Information

Last Name: ______________________________ First Name: _______________ Middle Initial: ___

Nickname: ____ Date of Birth: ___________________

For Minor Patients, Please List Name of Parent, Legal Guardian, or Conservator (*if any of these apply to you)* ____

Messages

You allow SFHC to leave voice messages at the phone numbers you have given us. You can opt out of this service at any time.

Who You Allow Us to Share With

Please tell us with whom we can share, or release, information.

If you do not want ANYTHING told to or shared with ANYONE check here: ☐

Person #1:___________________________________ Contact # ________________Relation: _________

If the patient is under 18 years old, this person is allowed to give permission and make decisions for:

___ Medical Care ___ Immunizations

Person #2:_________________________________ Contact # __________________Relation: _________

If the patient is under 18 years old, this person is allowed to give permission and make decisions for:

___ Medical Care ___ Immunizations

Person #3:__________________________________ Contact # _________________Relation: _________

If the patient is under 18 years old, this person is allowed to give permission and make decisions for:

___ Medical Care ___ Immunizations

Patient Sign: ____ Date:______________

Parent/Guardian/Conservator Sign: ________________________________ Date:______________

____ (initial) *I have been asked if I want a copy of SFHC's Notice of Privacy Practices.*

This approval ends one year from the date signed or the date updated in writing.

SFHC FINANCIAL POLICY

For Medical, Dental, and Behavioral Health Services & Fees

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

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

Payment

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

- Any fees that you need to pay are due at the time of your visit. This policy is for patients with or without health insurance. We will take cash, check, or credit card.

- If you have insurance, your payment includes any unpaid:
  - ✓ Deductibles
  - ✓ Co-insurance
  - ✓ Co-payment amount
  - ✓ Non-covered fees from your insurance company

- Self-Pay or Prompt-Pay Patients Who Have Insurance (*when you pay at your visit*): Did you know that if you pay for your medical fees at the time of your visit, you may qualify for a 50% discount?
  - ✓ You don't need insurance to qualify
  - ✓ This does not include dental fees

Insurance

Here are some details that you should know about insurance.

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

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

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

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

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

SFHC FINANCIAL POLICY

(*Continued*)

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

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

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

If your insurance does not cover part of your fee:

- You might qualify for our sliding fee discount program for the things that are not covered.
- The Medical Clinic and the Dental Clinic have different rules.
- Diagnostic tests are billed separately (lab testing, diagnostic imaging, etc).

If you have questions about your bill or fees, our Billing Team is happy to help! Call us at 530-292-3478.

I have read and understand the details of the SFHC Financial Policy.

Patient Name: ____

Please print clearly

Patient Signature: ______________________________ Date: ______________

OR

Account Holder Name: ____

Please print clearly

Account Holder Signature: ___________________________ Date: ______________

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Health History

Please help us get to know you better

Name: ______________________ Date of Birth:______________ Date:______________

Allergies: Are you allergic to any medicine or food? ___No ___Yes

If yes, please list:

Medicine or Food	What happens when you take or eat it?
Example: penicillin	I break out in hives
Example: peanuts	I can't breathe
1.	
2.	
3.	

Medications you take - Please bring all current medications including over the counter medications, vitamins and supplements to your first visit. If you did not bring them, please list below. You can also provide your medication list.

Medicines	Dose	How many times a day	Prescribing Doctor

Specialists You See:

Name	For what problems	City	Phone

Medical History: Do you have, or have you been diagnosed and/or treated for any of the following conditions:

Yes	No	Health Condition	Yes	No	Health Condition
		Anemia/blood disorder			Kidney/urinary tract problems
		Arthritis			Liver problems or hepatitis
		Blood clots			Lung problems
		Bone/joint disease			Psychiatric illness ______________
		Cancer, where?______________			Skin problems
		Diabetes, type:______________			Stomach/bowel problems
		Epilepsy/seizure disorder			Stroke
		Eye disease, type: ______________			Thyroid, adrenal disease
		Ear, nose or throat problems			Tuberculosis
		Heart problems			Other:
		High blood pressure			Other:
		High cholesterol			Other:
		HIV/AIDS			Other:

Surgical/Hospitalization History

Type of Surgery/Hospitalization	Year

Preventative Care

Date of last complete physical with bloodwork ______ Colonoscopy Yes____ No____ If yes, what year? _______

Females only: Have you had a mammogram? Yes____ No____ If yes, what year? _______

Have you had a Pap Smear? Yes____ No____ If yes, what year? _______

Past Immunizations (Shots): Have you had any of the following shots?

Flu Date: ________ Have the record? No Yes

Pneumonia Date: ________ Have the record? No Yes

Tetanus Date: ________ Have the record? No Yes

Please help us learn more about you so we can better help you:

- Do you have a dentist?..Yes___ No ____
- Within the past 12 months, we worried whether our food would run out before we got money to buy more..Yes___ No ____
- Within the past 12 months, the food we bought just didn't last and we didn't have money to get more. ....Yes___ No ____
- Do you feel safe at home?..Yes___ No ____
- Have you fallen in the last year?..Yes___ No ____
- Are you afraid of falling? Yes___ No ____
- Who lives with you?

  ____

- What is your level of education?

  ____

- What kind of work do you do?

  ____

Is there anything else you want to discuss with us today? ________________________________

____

Patient Name:____ Date of Birth: ____________________

Family History: Have your close family members had any of the following?

Family Member	Medical Condition		
Mother ☐ Alive ☐ Passed Age: _______	☐ Anxiety ☐ Bipolar illness ☐ Cancer: Type___________ ☐ Depression Other:	☐ Diabetes: Type ________ ☐ Heart problems ☐ High Blood Pressure ☐ High Cholesterol	☐ Stroke ☐ Substance misuse-Alcohol/drugs ☐ Thyroid problems
Father ☐ Alive ☐ Passed Age: ______	☐ Anxiety ☐ Bipolar illness ☐ Cancer: Type___________ ☐ Depression Other :	☐ Diabetes: Type ________ ☐ Heart problems ☐ High Blood Pressure ☐ High Cholesterol	☐ Stroke ☐ Substance misuse-Alcohol/drugs ☐ Thyroid problems
Sister(s) # Alive: ________ # Passed:_______ Age(s): ______	☐ Anxiety ☐ Bipolar illness ☐ Cancer: Type___________ ☐ Depression Other:	☐ Diabetes: Type ________ ☐ Heart problems ☐ High Blood Pressure ☐ High Cholesterol	☐ Stroke ☐ Substance misuse-Alcohol/drugs ☐ Thyroid problems
Brother(s) # Alive: _______ # Passed:______ Age(s): ______	☐ Anxiety ☐ Bipolar illness ☐ Cancer: Type___________ ☐ Depression Other:	☐ Diabetes: Type ________ ☐ Heart problems ☐ High Blood Pressure ☐ High Cholesterol	☐ Stroke ☐ Substance misuse-Alcohol/drugs ☐ Thyroid problems
Maternal Grandmother # Alive: _______ # Passed:______ Age(s): _____	☐ Anxiety ☐ Bipolar illness ☐ Cancer: Type___________ ☐ Depression Other:	☐ Diabetes: Type _______ ☐ Heart problems ☐ High Blood Pressure ☐ High Cholesterol	☐ Stroke ☐ Substance misuse-Alcohol/drugs ☐ Thyroid problems
Maternal Grandfather # Alive: _______ # Passed:______ Age(s): ______	☐ Anxiety ☐ Bipolar illness ☐ Cancer: Type___________ ☐ Depression Other:	☐ Diabetes: Type _______ ☐ Heart problems ☐ High Blood Pressure ☐ High Cholesterol	☐ Stroke ☐ Substance misuse-Alcohol/drugs ☐ Thyroid problems
Paternal Grandmother # Alive: ______ # Passed:_____ Age(s): _____	☐ Anxiety ☐ Bipolar illness ☐ Cancer: Type___________ ☐ Depression Other:	☐ Diabetes: Type _______ ☐ Heart problems ☐ High Blood Pressure ☐ High Cholesterol	☐ Stroke ☐ Substance misuse-Alcohol/drugs ☐ Thyroid problems
Paternal Grandfather # Alive: ______ # Passed:_____ Age(s): _____	☐ Anxiety ☐ Bipolar illness ☐ Cancer: Type___________ ☐ Depression Other:	☐ Diabetes: Type _______ ☐ Heart problems ☐ High Blood Pressure ☐ High Cholesterol	☐ Stroke ☐ Substance misuse-Alcohol/drugs ☐ Thyroid problems

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Dental Screening for Medical and Behavioral Health Patients

Name: ________________________________ Date: ____________________

Phone: ________________________________ Date of Birth: ____________________

	Yes	No	If Yes, please describe
Are you having problems eating because of dental problems?			___less than 1 week or ___longer than 1 week
Do you have any mouth pain or any active dental problems today? If yes:			___less than 1 week or ___longer than 1 week
• Does it feel like tooth pain?			
• Does it feel like gum pain?			
• How long has this been going on?			
• Would you like to see our dentist for your dental problem if possible?			
Do you have any sores in your mouth or on your tongue?			
Do you have a dentist already?			
Do you have any major dental problems?			
Do you have dentures?			
How long has it been since you've seen a dentist?	_____In the last year; or _____Over 1 year Number of years? _____		

Provider Use Only:

Referral: ______ Warm Handoff to SFHC Dental ______ Sent to their Own Dentist ______ Not Required

Status: _____Urgent _____Emergent _____Routine _____Other ______________________________

Provider Initials: ________

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Name: ______________________ Date of Birth:____________ Date:______________

Please Circle Your Answers

SECTION I

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Feeling less interested in doing things you usually like to do	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

SECTION II

How often do you have a drink containing alcohol?	**Never**	**Monthly or less**	**2-4 times per month**	**2-3 times per week**	**4+ times per week**
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3-4	5-6	7-9	10+
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

SECTION III

In the past 12 months, have you used drugs other than those prescribed for medical reasons?	Yes	No
Have you taken non-prescription drugs to improve your thinking or help you deal with difficult emotions?	Yes	No
Have you taken drugs to forget work, school, or family pressures?	Yes	No
Have you continued to take non-prescription drugs to avoid the pain of withdrawal?	Yes	No
Do you have a difficult time getting through the week without using non-prescription drugs?	Yes	No

SECTION IV

Have you ever used tobacco?	Yes	No	
If no, have you ever used tobacco?	Yes	No	If yes, Quit Date___________
Do you vape?	Yes	No	

SECTION V

Do you have intense and persistent fear of a social situation in which people might judge you?	Yes	No
Do you fear that you will be humiliated by your actions?	Yes	No
Do you fear that people will notice that you are blushing, sweating, trembling, or showing other signs of anxiety?	Yes	No
Is your fear excessive or unreasonable?	Yes	No
Do you go to great lengths to avoid participating?	Yes	No
Have your symptoms interfered with your daily life?	Yes	No

SECTION VI

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**A few days**	**Several days**	**More than half the days**	**Nearly every day**
Feeling nervous, anxious or on edge	0	1	1	2	3
Not being able to stop or control worrying	0	1	1	2	3
Worrying too much about different things	0	1	1	2	3
Trouble relaxing	0	1	1	2	3
Being so restless that it is hard to sit still	0	1	1	2	3
Becoming easily annoyed or irritable	0	1	1	2	3
Feeling afraid as if something awful might happen	0	1	1	2	3

Is there anything bothering you today that you would like to talk to a counselor about?	Yes	No

Sierra Family Health Center
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Patient Rights and Responsibilities

<u>As a patient, you have the right to:</u>

- take part in your health care and treatment.
- know the names of the people caring for you.
- be treated with respect and dignity in a safe and private setting.
- be informed about your illness and treatment, including options for your care.
- change medical providers at Sierra Family Medical Clinic.
- get another opinion about your illness or treatment.
- privacy of your health records.
- talk with the clinic manager about any questions or problems with your care.
- know about services available through SFMC.
- receive respect for your cultural, social, spiritual and personal values and beliefs.
- know about legal reporting requirements.
- ask for special arrangements if you have a disability.
- ask for help with a living will or durable power of attorney for health care.
- refuse treatment, care and services as allowed by law.
- know the cost of your care and ways you may pay for your care.
- refuse to be included in any research program without limiting medical care or treatment.

<u>As a patient, you have the responsibility to:</u>

- tell your medical provider about your illness or problems.
- ask questions about your illness or care.
- show respect to both care givers and other patients.
- cancel or reschedule appointments so that another person may have that time slot.
- pay your bills on time.
- use medications or medical devices for yourself only.
- inform the medical provider if you become worse or you have an unexpected reaction to a medication.
- give written permission to release your other health records to Sierra Family Medical Clinic when necessary.
- provide SFMC a copy of your living will or durable power of attorney for healthcare matters.

If you have any questions, please ask your medical provider or the clinic manager.

Sierra Family Health Center
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Your Personal Patient Portal

Your patient portal is a secure website where you can view and update your personal and health information, as well as communicate with Sierra Family!

You now have convenient, safe and secure access to:

View:

- ⇨ Your visit summaries
- ⇨ Current medications
- ⇨ Upcoming appointments
- ⇨ Lab results
- ⇨ Educational materials
- ⇨ Messages from SFHC

Update:

- ⇨ Personal information
- ⇨ Phone number, address, emergency contacts
- ⇨ Preferred pharmacy

Communicate:

- ⇨ Send a general message to your provider
- ⇨ Request medication refills
- ⇨ Download your available health records
- ⇨ Transmit your available medical records to another provider
- ⇨ Request a new appointment

To access your portal, simply give your email address to a team member of Sierra Family.

Within an hour, you will receive an email with instructions on how to set up your personal patient portal.

15301 Tyler Foote Road
Nevada City, CA 95959
530-292-3478

8676 Marysville Road
Oregon House, CA 95962
530-692-9073

sierraclinic.org
Federally Qualified Health Center

You Can Help Support Sierra Family Health Center

At no cost to you!

Please Use One of Our Preferred Pharmacies:

Simply go to one of our preferred pharmacies, listed below, for your medications and SFHC will receive a small rebate on your purchase, at no cost to you! All you need to do is fill your prescriptions—you don't even have to tell them you're a patient with SFHC.

- **CVS Pharmacy**
  1005 Sutton Way, Grass Valley CA 95945
  906 E Main Street, Marysville CA 95901
  1274 Stabler Lane, Yuba City CA 95993
  11411 Deerfield Drive, Truckee CA 96161
  388 Elm Avenue, Auburn CA 95603

- **Raley's Pharmacy**
  692 Freeman Lane, Grass Valley

- **Rite Aid Pharmacy**
  720 Sutton Way, Grass Valley CA 95945

- **Save Mart Pharmacy**
  2054 Nevada City Highway, Grass Valley

Frequently Asked Questions

Q: Will it cost me more to go to one of these preferred pharmacies?

A: No. The cost to you should be the same at preferred pharmacies as at any other pharmacy. The rebate is covered by drug companies at zero cost to you.

Q: Do I need to tell the pharmacy that I am a patient at SFHC, and I want to use the rebate program?

A: No—the pharmacies will automatically know that you are a patient with us, and will give us the rebate without you saying anything.

Q: Should I ask to have my prescriptions transferred right away?

A: You can start with any prescriptions you receive at your visit today, or we can refill one of your ongoing medications. Please tell your healthcare provider which preferred pharmacy you would like to use. Then, at your convenience, you can ask that pharmacy to get all your prescriptions transferred there.

If you have any other questions, please ask your medical assistant or healthcare provider at your visit today.

Thank you for considering our preferred pharmacy program!