Central Neighborhood Health Foundation



THANK YOU FOR CHOOSING US TO BE YOUR PRIMARY HEALTHCARE PROVIDER

Central Neighborhood Health Foundation

Dedicated to caring for our community since 1967

@cnhfclinics – www.cnhfclinics.org

Message from Our Board Chairman

Central Neighborhood Health Foundation is proud to offer top quality health care to everyone regardless of their ability to pay. We offer primary health care, preventive care, and other related integrated health services to the uninsured, underinsured, and underserved. As a patient-centered organization, by mission we seek to provide appropriate and meaningful access to care for all those who come through our doors.

Today, many of our patients gained health coverage under the Affordable Care Act (ACA), also known as Obamacare beginning in 2014. We continue to strive to achieve high patient satisfaction and quality outcomes as part of delivering patient-centered care serving more than 20,000 patients in calendar year 2017.

As a designated Federally Qualified Health Center (FQHC), community health is a specialization which requires unique skills to ensure our patients have access to high-quality care and are active participants in their plan of care and treatment goals. As such, we participate as a vital safety net provider with many other community partners in Los Angeles County and the Inland Empire. With the evolution of the ACA, community health centers such as ours continue to take on a much more dominant role within the local health care delivery system.

We are committed to maintain sustainability by maximizing relationships with our patients and our community partners as we continue to become more engaged within the communities we serve and with our partners. Together we serve all through healing and hope.

James Mackey
Board Chairman

Welcome to Central Neighborhood

FEDERALLY QUALIFIED HEALTH CENTERS

Welcome to Central Neighborhood Health Foundation (CNHF)! We are a private, nonprofit Community Health Center and a proud Member of the National Health Service Corps. With our first health center dedicated in the City of Los Angeles in 1967, we have been proudly caring for your community for over 50 years.

CNHF has since expanded to include comprehensive primary and preventive care services at five locations in Los Angeles County and the Inland Empire. Our clinics provide services for the entire family with services from family planning to pediatric care and nutrition counseling – we are here for your health.

This booklet was designed to assist you and your family to access any and all of our services you might need. Please take a moment to review this information and ask your clinic staff if you have any questions. If you have general questions about obtaining services, or if you wish to make an appointment for services, you may call our Appointment Call Center at (323) 234-5000 for the Central Clinic, the Grand Clinic at (323) 325-5882, the Inglewood Clinic at (323) 778-4310, H Street Clinic at (909) 381-0803, and Long Beach Clinic (562) 380-1692.

We are dedicated to providing you with the highest quality care in our clinics. If you have a suggestion that may help us serve you better or would like to notify us of any decrease in quality, please take a moment to let us know. There are suggestion boxes located in every health center.

Thank you for choosing CNHF for your healthcare needs.

Sincerely,
Kenneth Orduna, PhD
CEO

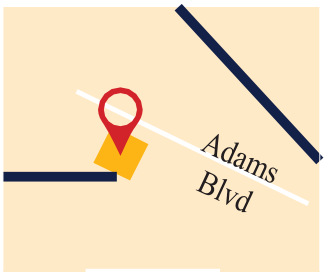
Central Neighborhood Health Foundation

Dedicated to caring for our community since 1967

Clinic Locations and Hours

Central Clinic

2707 S. Central Avenue, Los Angeles, CA 90011
Monday through Friday from 8:00 am to 5:00 pm
Phone Number: (323) 234-5000
Fax Number: (323) 231-3985



H Street Clinic

1329 N. H Street, San Bernardino, CA 92405
Monday through Friday from 8:00 am to 5:00 pm
Phone Number: (909) 381-0803
Fax Number: (909) 381-0823

Grand Clinic

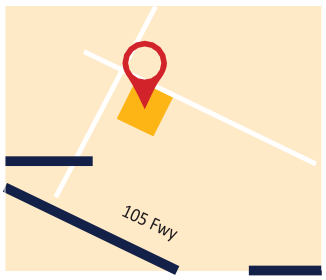
2614 S. Grand Avenue, Los Angeles, CA 90007
Monday through Friday from 8:00 am to 5:00 pm
Phone Number: (323) 325-5882
Fax Number: (213) 748-1618

Carmelitos – North Long Beach Clinic

711 E. Via Wanda Avenue, Long Beach, CA 90805
Monday through Friday 8:00 am to 5:00 pm
Phone Number: (562) 380-1692
Fax Number: (562) 228-0046

Inglewood Clinic

2710 W. Manchester Boulevard, Inglewood, CA 90305
Monday through Friday from 8:00 am to 5:00 pm
Phone Number: (323) 778-4310
Fax Number: (323) 778-0838



Call the clinic you'd like to visit to make an appointment.

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Patient Rights and Responsibilities

Central Neighborhood Health Foundation strives to offer you the highest quality health care in a courteous and timely manner. We want you to know what your rights and responsibilities are as a patient. We also encourage you to talk openly with the people taking care of you.

As a patient, you have certain rights, and understanding your rights will help you get the best possible care. We will make every effort to:

- Treat you with consideration and respect in a safe setting free from all forms of abuse or harassment.
- Your privacy will be protected.
- Keep all communication and records about your care confidential. In general, you have the right to see all the information in your health records.
- Clearly explain all clinic rules and regulations.
- Provide clearly written and spoken information in words you can understand.
- Provide all the information you need to make an informed decision about your care, including Information about your options, risks and benefits, possible outcomes, possible side effects, who is providing your care and costs.
- Respect your advance directives *(living will or durable power of attorney for health care)*, which express your wishes about resuscitation and other end-of-life decisions.
- Respect your decision to refuse care. To allow you to leave the clinic even if your provider advises you against it.
- Provide effective relief from pain and respect your right to refuse pain control.
- Provide you with freedom from restraints and seclusion of any form that is not medically necessary.
- Inform you that we sometimes use interns and externs *(medical students, practitioners and residence)* and that you have the right to refuse treatment from a health-care student, intern, or extern.
- You can request a consultation with another provider at any time.
- Provide you with all available information about possible research participation and obtain your informed consent.
- Involve you in discharge planning and inform your provider of any health-care requirements when you return home.
- Give you the opportunity to examine and receive an explanation of your bill regardless of source of payment.
- Allow you to express a concern or complaint and receive a prompt response. You also have the right to file a formal grievance if you are not satisfied with the resolution of your complaint.

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PATIENT RIGHTS AND RESPONSIBILITIES

Continued

Patients and visitors have responsibilities, and we ask that you make every effort to:

- Follow all clinic rules.
- Consider the rights of others and treat them with respect.
- Ask us for clear explanations and make informed decisions about your care and treatment. Relate full information about your health, medical history and insurance.
- Provide us with your advance directive information.
- Follow the recommended treatment plan and keep your follow-up appointments or notify us when unable to do so.
- Know what medications you are taking, why you are taking them and the proper way to take them according to your provider's order.
- Inform care providers of your level of pain and the effectiveness of provided treatment.
- Alert you health-care providers if you have concerns or feel your rights have not been properly respected.
- Pay medical bills promptly and contact us if you have any questions or financial problems.

In accordance with section 70577(k) and 71507(a), Title 22, of the California Administrative Code, CNHF and the medical staff have adopted certain patient rights. The undersigned acknowledges that he/she received a copy of the Patient's Bill of Rights.

Patient Name: _____

Patient Date of Birth: _____

Patient Signature: _____

Date: _____

If under 18 or otherwise unable to sign themselves, please sign below as the patient's guardian or witness.

Name: _____

Patient Date of Birth: _____

Guardian or Witness Name: _____

Guardian or Witness Signature: _____

Date: _____

What We Ask from You

1. **Keep My Appointment:** I will keep all my scheduled appointments. If I cannot keep my appointment I will call the clinic and cancel my appointment at least 24 hours before my scheduled appointment time.
2. **Use My Insurance:** I will inform clinic staff of any private or public (e.g. MediCal, Medicare) health insurance I have. I will provide all financial and personal documentation which may help to qualify me for clinic services or public insurance.
3. **Call for Appointment:** If I am feeling bad or have a question about my health care I will call the clinic nurse. If I feel I need to come into the clinic for immediate medical care, case management, social services or prescription refills, I will call first. If I walk in to the clinic without calling first, I understand that I may or may not be seen.
4. **Respect Other Clients And Staff:** I promise to respect the privacy, dignity and personal safety of all clients and staff of the clinic. I will not take anything from the clinic without first asking staff permission.
5. **Be On Time:** I will come to all my appointments on time, or I will call and reschedule my appointment.
6. **No Street Drugs or Alcohol:** I will not use any street drugs, or misuse prescription drugs or alcohol before my appointment. I commit to come to all my appointments sober.
7. **No Weapons:** I will not bring any weapon of any kind into the clinic area at any time. I understand that "weapons" include guns, knives, sprays (including pepper and mace), stun guns, or personal protection devices of any kind. I understand that if I bring a weapon into the clinic I may be asked to leave the clinic. I may also be transferred to another facility for my care. If I am legally permitted to carry a weapon or personal protection device (e.g., peace officer) I will notify the front desk upon my arrival, and appropriate arrangements will be made.
8. **Watch My Children:** I will supervise and control any family members and visitors, including children, who may come with me to the clinic.
9. **Take All My Medicines:** I will take all the medicine that I agree to take, or I will call my nurse. I will ask any questions I have about my medicines and when and how I should take them. I will call the clinic immediately if I decide to stop taking my medicines, if I do not understand how to take my medicines, or if my medicines make me feel worse.
10. **Report Other Care Or Illness:** I will inform the clinic staff if I am getting medical, psychiatric, mental health, case management or collaborative care (for example, acupuncture or herbal remedies, etc.) at any other clinic or anywhere else. I will inform the clinic staff if I have a fever, rash, cough, or eye drainage.
11. **Safer Sex/Safer Drug Use:** I will use safer sex and/or safer drug use practices with all my partners. If I do not understand how to do this I will talk to clinic staff about how to prevent disease transmission.
12. **Responsible For My Care:** I understand that I am ultimately responsible for my own health care and for that of my family. It is my responsibility to make and keep appointments for preventive care, follow-up on referrals and contact the health center when requested.
13. **Providing Current Information:** I understand that I am responsible for providing current contact information, an accurate health history and current medications, and participating in self-management activities.

Patient Name: _____

Signature: _____ Today's Date: _____

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NOTICE OF PRIVACY PRACTICES

Patient Name:_____ Date of Birth: _____

I understand that my health information may include information both created and received by Central Neighborhood Health Foundation (CNHF), that it may be in the form of written or electronic records or spoken words, and may include information about my health and mental health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that CNHF may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment *(including activities performed by physician, nurse practitioner or other healthcare providers directly delivering care at CNHF)*;
- refer to consult with, coordinate among, and manage along with other healthcare providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related health information or insurance companies or other who may be responsible to pay for some or all of my health care;
- Perform various office, administrative and business functions that support my Provider's efforts to provide me with, arrange, and be reimbursed for quality, cost effective healthcare.

I also understand that I have the right to receive and review a written description of how the health center will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made, the information practices followed by the employees, staff, and other office personnel of CNHF, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of privacy Practices. I also understand that the most current version of the Central Neighborhood Health Foundation Notice of Privacy Practices or a summary in effect will be posted in the waiting/reception area and that a copy is available upon request.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that CNHF is not required by law to agree to such requests.

I hereby give permission to disclose and release information to the following persons for the specific purpose of managing my healthcare. *(Please print.)*

Name:_____ Relationship: _____

Phone Number: _____

Name:_____ Relationship: _____

Phone Number: _____

By signing below, I agree that I have received, reviewed and understand the information above. I understand I have the right to revoke this CONSENT and provided that I do so in writing, except to the extent that has already been used or information disclosed in reliance on this consent.

Patient Name:_____ Signature: _____

Today's Date: _____

Patient Representative:_____ Signature: _____

Today's Date:_____ Relationship to Patient: _____

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PATIENT INFORMATION *Please print.*

Last Name:_____ First Name:_____ MI: _____

Preferred Name:_____ Date of Birth: _____

Social Security Number or Individual Taxpayer Identification Number: _____

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed

Sex Assigned at Birth: ☐ Male ☐ Female

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other: _____

Email address: _____

How would you like us to contact you about your appointments? *(more than 1 can be selected)*

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Text Message ☐ Email Address

Can we leave a voicemail at the above phone number(s)? ☐ Yes ☐ No ☐ Other: _____

Address Information

Physical:_____ Mailing:_____

City:_____ City: _____

State:_____ Zip Code:_____ State:_____ Zip Code: _____

Home Phone:_____ Cell Phone: _____

Employer Information

Employer Name: _____

Work Phone:_____ Extension: _____

Secondary Authorized Party

Spouse/Partner Name *(if applicable)*: _____

Employer Name:_____ Phone Number: _____

Emergency Contact Information

Name:_____ Relationship: _____

Phone Number: _____

Name:_____ Relationship: _____

Phone Number: _____

Insurance Information

Primary Insurance Company:_____ Effective Date: _____

Subscriber Name *(if not self)*: _____

Subscriber DOB:_____ Subscriber SSN:_____ ID#: _____

Group #:_____ Relationship to Patient: _____

Secondary Insurance Company:_____ Effective Date: _____

Subscriber Name *(if not self)*: _____

Subscriber DOB:_____ Subscriber SSN:_____ ID#: _____

Group #:_____ Relationship to Patient: _____

If you do not have insurance coverage, are you applying for our Sliding Scale Program? ☐ Yes ☐ No

PATIENT INFORMATION

Continued

Patient Name:_____ Date of Birth: _____

The information you share with us below allows us to receive continued support through the Bureau of Primary Health Care as a Federally Qualified Health Center. Your cooperation is greatly appreciation and your answers will be held in the strictest confidence.

Sexual Orientation: ☐ Lesbian or Gay ☐ Straight ☐ Bisexual ☐ Something Else ☐ Don't Know

Would you like to have a translator for your visit? ☐ Yes ☐ No

What language?_____

What is your current housing status? *(Where did you spend last night?)*

☐ Permanent Housing/Not Homeless *(Own or Rent)* ☐ Homeless Shelter ☐ Public Housing

☐ Doubling Up *(living with another family in the same household)* ☐ Street

☐ Temporary Situation/Transitional

What is your work condition? ☐ Full Time ☐ Disabled ☐ Retired ☐ Seasonal Worker

☐ Student ☐ Not Working

If you are under 18 years of age, are either of your parents: ☐ Seasonal ☐ N/A

What is your race? *(Select all that apply)*

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian

☐ Other Pacific Islander ☐ White ☐ Other: _____

Are you Latino or Hispanic? ☐ Yes ☐ No

Are you a veteran? ☐ Yes ☐ No

CLINICAL HISTORY & PHYSICAL FORM

Please print.

Name:_____ Age:_____ DOB: _____

Previous Provider: _____

Referring Provider *(if applicable)*: _____

Reason for Visit: _____

Your complete medication history is important. Patients are required to update this list for accuracy at each appointment. If for some reason you are unable to fill out this form, please bring all your medications you are taking, in their original containers, to your first appointment.

Allergies: Are you allergic to medications, iodine, shellfish, food, tape, or latex?

List each substance and your reaction.

Allergy:_____ Reaction: _____

Allergy:_____ Reaction: _____

Allergy:_____ Reaction: _____

Check if no known allergies: ☐

Current Medications: List all prescription, non-prescription, and over-the-counter medications that you use including herbals, eye drops, nutritional supplement(s), inhalers, etc. List any medication being held prior to a scheduled surgery, and any medication that you have recently completed *(including antibiotics)*.

Start Date:_____ Medication:_____ Amount and Dose: _____

Route *(ex: mouth, spray)*:_____ Directions *(ex: 2 times daily)*: _____

Purpose: _____

Start Date:_____ Medication:_____ Amount and Dose: _____

Route *(ex: mouth, spray)*:_____ Directions *(ex: 2 times daily)*: _____

Purpose: _____

Start Date:_____ Medication:_____ Amount and Dose: _____

Route *(ex: mouth, spray)*:_____ Directions *(ex: 2 times daily)*: _____

Purpose: _____

Start Date:_____ Medication:_____ Amount and Dose: _____

Route *(ex: mouth, spray)*:_____ Directions *(ex: 2 times daily)*: _____

Purpose:_____

Please ask for an extra sheet if taking more than 4 medications currently.

Pharmacy Name: _____

Pharmacy Phone:_____

CLINICAL HISTORY & PHYSICAL FORM

Continued

Past Medical History:

(Please check all that apply)

☐ None ☐ Allergy: Food ☐ Allergy: Seasonal ☐ Anxiety ☐ Arthritis *(type)*: _____

☐ Asthma ☐ Bleeding Difficulties ☐ Coronary Artery Disease ☐ Depression

☐ Diabetes-Diet Controlled ☐ Diabetes-On Insulin ☐ Diabetes-Oral Meds ☐ Emphysema

☐ Heart Disease ☐ Hepatitis A B or C ☐ High Blood Pressure ☐ High Cholesterol

☐ HIV ☐ Hyperthyroid ☐ Hypothyroid ☐ Loss of Consciousness ☐ Osteoporosis

☐ Seizure ☐ Sleep Apnea ☐ Stroke/TIA ☐ TB

☐ Cancer:_____ Type of Treatment: _____

☐ Other: _____

Past Surgical History:

(Please list type of surgery and year.)

1._____ 2. _____

3._____ 4. _____

5._____ 6. _____

Social History:

Tobacco Use ☐ Never ☐ Quit ☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Chewing Tobacco

If you have quite, when?: _____

Alcohol Use ☐ None ☐ Socially ☐ Daily ☐ Heavy

Have you ever been treated for alcoholism?: ☐ Yes ☐ No

Drug Use ☐ None ☐ Marijuana ☐ Amphetamines ☐ Other: _____

Have you ever been treated for drug use?: ☐ Yes ☐ No

Exercise ☐ None ☐ 1 -2x/week ☐ 3-4x/week ☐ 5-6x/week Type: _____

Caffeine Use ☐ None ☐ Occasional ☐ Daily ☐ How much?:_____

Are there any religious beliefs that would affect your medical care?: ☐ Yes ☐ No

If yes, please explain: _____

Education: *(Please check the highest level you have completed)*

☐ Grade School ☐ High School ☐ College ☐ Post Graduate

Occupational History:

Have you altered your job as a result of the problem you brought here today? ☐ Yes ☐ No

If yes, please explain: _____

If you are currently off work as a result of the problem, how long have you been off?: _____

CLINICAL HISTORY & PHYSICAL FORM

Continued

Family History:

Mother – Age: _____ Living: ☐ Deceased: ☐ Medical History or Cause of Death: _____

☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐ Cancer, Type: _____

☐ Other: _____

Father – Age: _____ Living: ☐ Deceased: ☐ Medical History or Cause of Death: _____

☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐ Cancer, Type: _____

☐ Other: _____

Brothers – Age: _____ # Living: ☐ # Deceased: ☐ Medical History or Cause of Death: _____

☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐ Cancer, Type: _____

☐ Other: _____

Sisters – Age: _____ # Living: ☐ # Deceased: ☐ Medical History or Cause of Death: _____

☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐ Cancer, Type: _____

☐ Other: _____

Children – Age: _____ # Living: ☐ # Deceased: ☐ Medical History or Cause of Death: _____

☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐ Cancer, Type: _____

☐ Other: _____

For Patients Assigned Female at Birth:

Are you pregnant? ☐ Are you breast feeding? ☐ # of Pregnancies/Deliveries: _____

Date of first menstrual period? _____ Date of last menstrual period? _____

Last Mammogram: _____ Last Pap: _____ Last Bone Density Scan? _____

For Patients Assigned Male at Birth:

Do you experience impotency? _____ Last Prostate Exam: _____

Vaccines:

(Check one for each vaccine)

Tetanus: ☐ Within the past 10 years ☐ Unknown ☐ Never

Pneumococcal: ☐ Within the past 5 years ☐ Unknown ☐ Never

Influenza: ☐ Within the past year ☐ Unknown ☐ Never

Pediatric *(child only)*: ☐ Up-to-date ☐ Unknown ☐ Never

Other Screenings: _____

NON-DISCRIMINATION NOTICE

Section 1557 of the Affordable Care Act (ACA)

Central Neighborhood Health Foundation complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Central Neighborhood Health Foundation does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity, and gender expression.

Central Neighborhood Health Foundation:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic format, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information is written in other languages

If you believe that Central Neighborhood Health Foundation has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, and gender expression, you can file a grievance with:

Patient Relations

Phone number: 213-536-5815 ext. 013
Fax number: 213-478-0172 Email address: rble@cnhfclinics.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Patient Relations Office is available to help you.

You can 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

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).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATTENTION: If you speak Spanish, Chinese, Vietnamese, Tagalog, Korean, Armenian, Persian (Farsi), Russian, Japanese, Arabic, Punjabi, Mon-Khmer or Cambodian, Hmong, Hindi and Thai, language assistance services, free of charge, are available to you. Call 1-855-436-1234

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-436-1234

注意:如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-436-1234

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-436-1234

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-436-1234

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-436-1234

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-855-436- 1234

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما 1-855-436-1234 بگیرید تماس. ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-436-1234

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-855-436-1234まで、お電話にてご連絡ください。برقم

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل 1-855-436-1234 ਧਆਨਦਓ:ਜੇਤੁਸਪੰਜਾਬੀਬੋਲਦੇਹ,ੋ ਤਭਾਸ਼ਾਵੱਚਸਹਾਇਤਾਸੇਵਾਤੁਹਾਡੇਲਈਮੁਫਤਉਪਲਬਧਹਾ।ੈ 1-855-436-1234

Please, take a look at the full document. It has important information regarding patients that speak other languages.

AUTHORIZATION TO CONSENT TO TREATMENT

I,_____, the undersigned, do hereby authorize Central Neighborhood Health Foundation (CNHF) to act as agents for the undersigned to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician or surgeon and/ or any practitioner licensed under the provisions of the Medical Practice Act or any staff of CNHF whether such treatment is rendered at the clinic or at the hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our foresaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgement may deem advisable.

This authorization shall remain effective for one year unless it is revoked in writing and delivered to CNHF.

LIMITS OF CONFIDENTIALITY

Federal and state regulation require that strict client confidentiality be maintained at all times, except when there is evidence of potential injury to oneself and/or others; potential injury to you by someone else; suspected child abuse, spousal abuse, and/or elder abuse; or certain medical conditions that require reporting to the Department of Health or Department of Motor Vehicles. In such instances we are required to report to the appropriate authorities/agencies. In accordance with these regulations, we will not disclose any information about you or your health information to any person or institution including school personnel and other family members, without your written consent, except as set forth above.

RELEASE OF INFORMATION

I, the undersigned, do hereby authorize CNHF, upon injury, to make available to the public certain basic information about the patient, including name, address, age, sex, general description of the reason for treatment (whether an injury, burn, poisoning, or other conditions) and general nature of the injury, burn, poisoning, or other condition, and general conditions. If the patient or that patient's legal representative does not want such information to be released, he/she must have a written request or such information to be withheld.

CNHF will obtain the patient's consent and his/her written authorization to release information, other than basics information, concerning the patient, except in those circumstances when CNHF is permitted or required by law to release information.

ADVANCED DIRECTIVES

Advanced Directives are legal documents that provide instructions regarding your medical care decisions. We encourage you to discuss your treatment decisions with the medical staff.

Would you like to receive more information regarding Advanced Directives? ☐ Yes ☐ No

If yes, please ask the clinic staff for more information.

Patient Name:_____ Signature: _____

Today's Date: _____