IN ORDER FOR YOUR CHILD TO BE SEEN, IT IS IMPORTANT THAT YOU:

Fill out ALL FORMS completely

SIGN Consent Forms

WE NO LONGER WRITE OFF BLANACES, IF YOU HAVE NO DENTAL INSURANCE, PLEASE FILL OUT A SLIDING SCALE APPLICATION AND PROVIDE PROOF OF INCOME PRIOR TO SERVICES BEING RENDERED

PLEASE BRING THE FILLED OUT PAPERWORK TO THE DENTAL VAN OR YOUR SCHOOL OFFICE

We are In-Network with the following Dental Insurances:

Guardian, Humana, Anthem Blue Cross, Cypress, MediCal, Delta Dental

Redwoods Rural Health Center

MOBILE DENTAL

Consent to Treatment, Assignment of Benefits & Release of Information

Name of Child: _____ Date of Birth: _____

Adult Providing Consent: _____ Relation to Child: _____

- With my signature below, I authorize Redwoods Rural Health Center to provide diagnosis and/or treatment of dental conditions for the above-named child through the Mobile Dental Program.
- With my signature below, I authorize Redwoods Rural Health Center and my child's school/childcare facility: (please write in the name of your child's school) _____, to exchange information for the purposes of scheduling and treatment through the RRHC Mobile Dental Van program.
- I understand that Redwoods Rural Health Center will provide only those services that I have authorized below. **I have <u>checked the appropriate boxes in each section and signed</u> next to each type of service for which I am granting authorization:**

_____ **Dental Exam,** including dental x-rays

_____ **Preventive Services:** ☐ tooth cleaning, ☐ oral hygiene instruction, ☐ sealants, ☐ fluoride treatment

_____ **Restorative Services:** ☐ filling, ☐ stainless steel crown, ☐ pulpotomy (*Anesthesia is used for these procedures*)

_____ **Extraction of Primary Teeth:** ☐ Removal of primary (baby) teeth that cannot be restored through other treatments. (*Anesthesia will be used for this procedure.)*

*If **extraction of permanent teeth** is recommended, a separate consent form will be required.*

- I understand that mobile dental visits are scheduled during school hours. I have checked **one** box below to indicate whether or not I want to be present when my child is seen. ***<u>I understand that there is insufficient room in the mobile dental van to allow me to be present in the treatment area, but that I may wait nearby during my child's visit(s).</u>***

  ☐ I want to be present at all of my child's dental appointments.

  ☐ I want to be present only at my child's dental appointments for restorative services or extractions.

  ☐ I want to be present only at my child's dental appointments for extractions.

  ☐ I do not need to be present at my child's dental appointments.

  If you have requested to be present, we will call you with dates and times of your child's intended appointment times. Please provide contact information below:

  Daytime phone number(s): _____

- I understand there is a copy of the Notice of Privacy Practices of Redwoods Rural Health Center available to me at the Southern Humboldt Family Resource Center and in the Mobile Dental Van. I understand that Redwoods Rural Health Center shares certain types of information with other health care providers, public agencies and payors, as a part of our health care operations. I understand that I have the right to request that specific information not be shared, and that I should request more information if I have questions or concerns.
- ***For patients with Insurance, including Medi-cal:*** You must present your current Insurance or Medi-Cal card.
- I certify, under penalty of perjury, that the information provided is true and correct to the best of my knowledge.

Signature of Parent or Legal Guardian: _____ Date: _____

Redwoods Rural HEALTH CENTER

Family Health Care

Treatment of a Minor Consent & Delegation

_____ I, _____ am the **parent of the child** listed below and there are no court orders now in effect that would prohibit me from conferring the power to consent upon another person.

_____ I,_____ am the **legal guardian or legal custodian** of the child by court order (copy attached, if available), and there are no other court orders in effect that would prohibit me from conferring the power to consent upon another person.

I give my consent to Redwoods Rural Health Center to provide medical, mental health or dental treatment to my child. Further, I authorize the following individual(s)

Delegate 1 Name:_____ Address: _____
Phone Number: _____

Delegate 2 Name:_____ Address: _____
Phone Number: _____

Delegate 3 Name:_____ Address: _____
Phone Number: _____

to consent to the treatment **of the following** child, when I am unavailable:

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

The power that I confer is specifically limited to health care decision-making, and it may be exercised only by the person(s) named above. The person(s) named above may consent to the following examinations and treatment for my child and may have access to any and all records, including, but not limited to, insurance records regarding any such services (check all that apply), as permitted by law.

___ medical, ___ lab tests, ___ immunizations, ___ mental health, ___ dental, ___ acupuncture

I confer the delegation of consent freely and knowingly in order to provide for the child and not as a result of pressure, threats or payments by any person or agency. This document shall remain in effect until it is revoked by my written notification.

_____/_____/_____
Signature of Parent or Legal Guardian | Printed Name | Date

Relationship to Minor _____

_____/_____/_____
Witness Signature | Printed Name | Date

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Medical (707) 923-2783 • Dental (707) 923-4313 • Fax: 707-923-2543

REDWOODS RURAL HEALTH CENTER
101 WEST COAST ROAD/PO BOX 769 REDWAY, CA 95560

PATIENT INFORMATION FORM

PATIENT INFORMATION

NAME: _____
MAILING ADDRESS: _____
_____
CITY: _____ ZIP _____
PHYSICAL ADDRESS: _____
CITY: _____ ZIP: _____
PHONE NUMBER: _____

SOCIAL SECURITY #: _____
DRIVER'S LICENSE #: _____
DATE OF BIRTH: _____ SEX: M☐ F☐
MARITAL STATUS: SNGL☐ MRD☐ DIV☐ WDW☐
SPOUSE'S NAME: _____
EMPLOYER: _____
WORK PHONE: _____

IN ORDER FOR US TO MEET FEDERAL FUNDING REQUIREMENTS, PLEASE ANSWER THE FOLLOWING QUESTIONS:

ARE YOU A VETERAN OF THE UNITED STATES OF AMERICA? YES☐ NO☐

ARE YOU A SEASONAL AGRICULTURAL WORKER? YES☐ NO☐

ARE YOU HOMELESS (LACK HOUSING OR LIVING IN TRANSITIONAL HOUSING) YES☐ NO☐

RACE/ETHNICITY: WHITE☐ HISPANIC☐ AFRICAN AMERICAN☐ NATIVE AMERICAN☐
CHINESE☐ JAPANESE☐ FILIPINO☐ OTHER ASIAN☐ DECLINE TO ANSWER☐

MONTHLY INCOME

CIRCLE YOUR FAMILY'S MONTHLY GROSS INCOME LEVEL THAT CORRESPONDS TO YOUR HOUSEHOLD SIZE					
HOUSEHOLD SIZE	AT OR BELOW	BETWEEN	BETWEEN	BETWEEN	ABOVE
1	$1063	$1064-$1467	$1468-$1595	$1596-$2127	$2128
2	$1437	$1438-$1983	$1984-$2156	$2157-$2874	$2875
3	$1810	$1811-$2498	$2499-$2715	$2716-$3620	$3621
4	$2183	$2184-$3013	$3014-$3275	$3276-$4366	$4367
5	$2557	$2558-$3529	$3530-$3836	$3837-$5114	$5115

RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

NAME: _____
MAILING ADDRESS: _____
_____
CITY: _____ ZIP _____
PHYSICAL ADDRESS: _____
CITY: _____ ZIP: _____
PHONE NUMBER: _____

SOCIAL SECURITY #: _____
DRIVER'S LICENSE #: _____
DATE OF BIRTH: _____ SEX: M☐ F☐
MARITAL STATUS: SNGL☐ MRD☐ DIV☐ WDW☐
SPOUSE'S NAME: _____
EMPLOYER: _____
WORK PHONE: _____

IF PATIENT IS UNDER 18

MOTHER'S NAME: _____
MAILING ADDRESS: _____
CITY: _____ ZIP: _____
HOME PHONE: _____
WORK PHONE: _____

FATHER'S NAME: _____
MAILING ADDRESS: _____
CITY: _____ ZIP: _____
HOME PHONE: _____
WORK PHONE: _____

EMERGENCY CONTACT

_____

NEAREST RELATIVE (OUTSIDE OF HOUSEHOLD) CITY & STATE PHONE NUMBER

METHOD OF PAYMENT

❑Private Pay ❑ CMSP/*Issue Date*: ____/ ____/ ____ ❑Medicare #_____

❑Insurance ❑ MediCal/*Issue Date*: ____/ ____/ ____ ❑Other: _____

If you are covered by Insurance, Medi-Cal or Medicare, *please* present your card to the receptionist.

We have a sliding-fee scale for low-income patients. Please tell the receptionist if you are interested in this program.

Payment for office examinations and treatment is required at the time services are rendered unless other arrangements have been made

I, the undersigned, give my permission for Redwoods Rural Health Center to administer medical care, and agree to be responsible for payment of all Health Center Services

_____ ____/_____/_____

Signature of Patient, Parent or Legal Guardian *Date*

Pursuant to Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, Redwoods Rural Health Center does not discriminate on the basis of race, color, national origin, handicap, or age.

INSURANCE OR MEDICARE SECONDARY INSURANCE INFORMATION

We are happy to assist you in submitting your insurance claims; however, please remember that you are responsible for ensuring that Redwoods Rural Health Center is paid for services provided to you. If your insurance carrier does not pay us within 60 days, it becomes your responsibility to do so and contact your insurance company to find out why payment has not been made. We will reimburse you when your insuance carrier remits a payment.

Your Insurance Carrier:_____ID# _____ Group #_____

Policy Holder: ❑Self ❑Spouse ❑Parent ❑Other Policy Holder Name: _____

Claims Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

AUTHORIZATION FOR RELEASE

***I HEREBY AUTHORIZE** the release of any and all information acquired in the course of examination/treatment, to my insurance company.*

***I HEREBY AUTHORIZE** and request the payment of medical benefits directly to Redwoods Rural Health Center for medical services rendered to me. This assignment will remain in effect until revoked by me in writing. A photocopy or scan of this agreement is to be as valid as the original.*

_____ ____/_____/_____

Signature of Patient, Parent or Legal Guardian *Date*

Redwoods Rural Health Center Patient Health History

Medical Clinic (707) 923-2783 Dental Clinic (707) 923-4313

Please answer the following questions. For Yes/No questions, please mark each question individually.
If you are not sure about a question, please circle the number or letter in front of the question.

Patient Name: First _____ Last _____

Names used previously: _____ **Phone:** _____

Date of Birth: _____ **Gender:** ☐ Male ☐ Female **Email:** _____

1. Why are you here today? _____

2. When was your last health exam? _____ **3. Who is your doctor?** _____

4. When was your last dental visit? _____ **5. Who is your dentist?** _____

6. Medical History: Have you ever had...

	No	Yes/Year
A. **Damaged or artificial heart valve**		
B. Congenital heart lesion or murmur		
C. Cardiovascular heart disease		
1. Chest pain during/after exertion		
2. Shortness of breath		
3. Swelling of ankles or feet		
4. **Cardiac pacemaker**		
5. **Heart Attack/Stent placed**		
D. Abnormal blood pressure (high or low)		
E. Lung trouble, Asthma, Tuberculosis, COPD		
F. Sinus problems		
G. Hives or skin rash		
H. Allergy		
I. Diabetes		
1. Frequent urination (more than 6 X per day)		
2. Frequent thirst/dry mouth		
	No	**Yes/Year**
J. Hepatitis A, B, or C		
K. Arthritis		
L. Rheumatism or painful swollen joints		
M. **Joint prosthesis**		
N. Endocrine disorder, thyroid		
O. Stomach ulcer		
P. Kidney trouble		
Q. Persistent or bloody cough		
R. **Fainting spells or seizures**		
S. **Cancer/Radiation**		
T. HIV or AIDS		
U. **Blood disorder, anemia or hemophilia**		
1. Abnormal bleeding with surgery or trauma		
2. Bruising easily		
3. Blood transfusion		
V. Family member w/bleeding disorder		

7. Medications: ☐ Check here if you do **NOT** take **ANY** medications (please provide complete med list on next page)

Are you taking...	**No**	**Yes**
A. Anti-biotics or Sulpha Drugs		
B. Anticoagulants (blood thinners)		
C. Medicine for high blood pressure		
D. Cortisone or other steroids		
E. Sleeping Medications		
F. Antihistamines		
G. Aspirin		
	No	**Yes**
H. Insulin or diabetes drugs		
I. Heart Drugs, nitroglycerin, digitalis		
J. Oral Contraceptives		
K. Other medications		
L. Bisphosphonate (for Osteoporosis)		
M. Chemotherapy (or previously)		

Patient Name:_____ DOB: _____

8. Medications ☐ No Medications

Brand Name	Generic Name	Start Date	Directions
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

9. Allergy ☐ No allergies

Name	Reaction	Name	Reaction
1.		5.	
2.		6.	
3.		7.	
4.		8.	

10. Past Medical History ☐ No known past medical history

Condition	Year Began
1.	
2.	
3.	
4.	
5.	
6.	

11. Past Surgeries ☐ No past surgeries

Surgery	Year
1.	
2.	
3.	
4.	
5.	
6.	

12. List hospitalizations in the past 5 years:

Reason	What Hospital	Date

13. Female Patients:

LMP: __/__/__ Currently Pregnant: Y/N Breast Feeding: Y/N

Please indicate # of: Pregnancies: _____ Live Births: ____ Ectopic: ____ Miscarriages: ____ Abortions: ____

14. Family History ☐ No relevant family history ☐ I am adopted/fostered

Diagnosis	Family Member	Comments
1.		
2.		
3.		
4.		
5.		

Patient Name:_____ DOB: _____

Social History

15. Alcohol Use ☐ yes ☐ no ☐ former

Type	
Drinks per Day	
Year Quit	

16. Tobacco Use ☐ yes ☐ no ☐ former

Type of tobacco	
# Used per Day	
Years Used	
Year Quit	

17. Health Maintenance Last Test Date:

Cholesterol Check	
PSA	
Colonoscopy	
Bone Density Scan	
Ultrasound Liver Test	
Tetanus Vaccine	
Hepatitis Test	
HIV Test	
Anemia Test	

18. Disease Management Last Test Date:

HgbA1C	
Abdominal Ultrasound	
Cardiac Stress Test	
Chest X-ray	
Echocardiogram	
EKG	
Eye Exam	

19. Recreational Drug Use ☐ yes ☐ no ☐ former

Type of Drug(s)	
Currently Using	**Yes / No** (circle)
Years Used	
Year Quit	

20. List any other diseases or problems which might be of concern:

_____

21. Advance Directives (Resuscitation Wishes)

Date Reviewed: _____ ☐ None ☐ DNR ☐ Living Will ☐ Durable Power of Attorney ☐ HC Proxy

***I have filled out this health history completely and accurately to the best of my knowledge.**

_____ _____

Signature (Patient or Responsible Party) **Date**

_____ _____

Printed Name of Responsible Party **Relationship to Patient**

----------**Office Use**----------

Review Date: _____ **Provider:** _____ **Review Date:** _____ **Provider:** _____

Review Date: _____ **Provider:** _____ **Review Date:** _____ **Provider:** _____

Review Date: _____ **Provider:** _____ **Review Date:** _____ **Provider:** _____

Bisphosphonates

Please check yes in the box next to the following medications if you are currently taking them or have EVER taken them the past.

Drug name	Check if yes/year	Check if No
Actonel		
Atelvia		
Boniva		
Didronel		
Etidronate		
Fosamax		
Alendronate		
Skelid		
Aredia		
Prolia		
XGEVA		
Reclast/Aclast		
Zometa		

If you are currently taking or have taken any of the above medications in the past, please note the risk of osteonecrosis of the jaw with dental procedures. Please know that you may have to be referred to see a specialist for further treatment. Options will be discussed with your dentist.

Patient Name Printed _____ Date_____

Patient Signature _____

SIGNATURE FOR INFORMED CONSENTS

I have had the opportunity to read the following informed consents:

Please **initial and sign.**

____ 1) The Redwoods Rural Health Center "No Show Policy"

____ 2) Notice of Privacy Practices

____ 3) Consent for Local Anesthesia (for Dental only)

____ 4) The Dental Material Facts Sheet (for Dental only)

Patient/Guardian Signature _____ Date _____

Patient's printed name _____ Date _____

In order to save paper, these materials may be viewed in our Clinic upon your arrival or downloaded and viewed from our website.

Website Address: ~~http://www.rrhc.org~~

Look under the Download Forms section.

Redwoods Rural
HEALTH CENTER
Family Health Care

Sexual Orientation and Gender Information

Mandated health reporting requires us to gather information about our patients' gender and sexual orientation.

Responses will be kept private and are confidential in your health record. The data we gather will be used only for healthcare quality improvement.

Gender Identity:

- ☐ Female
- ☐ Additional gender category or other, please specify: _____
- ☐ Choose not to disclose
- ☐ Female-to-Male (FTM)/Transgender Male/Trans Man
- ☐ Genderqueer, neither exclusively male nor female
- ☐ Male
- ☐ Male-to-Female (MTF)/Transgender Female/Trans Woman

Sexual Orientation:

- ☐ Straight or heterosexual
- ☐ Bisexual
- ☐ Choose not to disclose
- ☐ Don't know
- ☐ Lesbian, gay or homosexual
- ☐ Something else, please describe: _____

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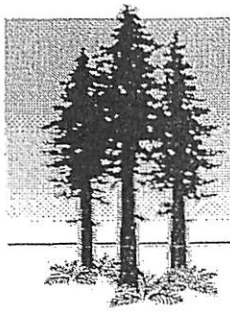


Redwoods Rural
HEALTH CENTER
Family Health Care

AUTHORIZATION FOR RELEASE

"Health Insurance Portability & Accountability Act (HIPAA) – Consent for Purposes of Treatment, Payment and Health Care Operations"

I consent to the use or disclosure of my protected health information by Redwoods Rural Health Center (RRHC) for the purpose of diagnosing or providing treatment to me; obtaining payment for my health care bills; and/or conducting health care operations. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations. I also have the right to revoke this consent, in writing, at any time, except to the extent that RRHC has taken action in reliance on this consent.

I authorize RRHC to use a variety of electronic communication methods including phone, text messages, and e-mail to contact me with health-related notifications. To serve me better and keep me healthy, the messages include appointment reminders, health tips, and information to help manage my health. I understand some communications are conducted via RRHC's contracted vendors and these messages are not a substitute for professional medical advice, diagnosis, or treatment. I authorize RRHC to disclose limited protected health information to other persons who may answer my phone, text messages, or e-mail. I know I may opt-out of receiving these communications from RRHC at any time by calling the health center at (707) 923-2783 or texting the word "STOP" in response to a text message.

I understand I have a right to review RRHC's Notice of Privacy Practices, which were made available to me prior to signing this document. The Notice of Privacy Practices is available in the reception area and on RRHC's website, www.rrhc.org and describes the types of uses and disclosures of my protected health information that will occur for my treatment, payment of my bills or in the performance of health care operations at RRHC.

*Patient Printed Name*_____ *Patient Birth Date:* ____/_____/_____

_____ *Signed Date:* ____/_____/_____

Signature of Patient, Parent or Legal Guardian Date

A photocopy or scan of this agreement is to be as valid as the original.

Redwoods Rural Health Center

Sliding Scale Application

Head of Household Information:

Name: (First, middle initial, Last):	Social Security Number:	Date of birth:	County:
Mailing Address:	City/State/Zip:	Home Phone:	Work Phone:
Homeless/Transitional Housing: Yes/No	Marital Status: : Single ☐ Widowed ☐ Divorced ☐		
# of people living in the home that share household expenses:	Married ☐ Separated ☐		

Income Information: Please complete for all adult household members who are employed: **PROOF OF GROSS INCOME MUST BE PROVIDED TO RRHC (RECENT PAYSTUB, INCOME TAX RETURN, STATEMENT OF FEDERAL OR STATE DEPOSITS). PERSONS NEEDING TO SELF DECLARE ARE REQUIRED TO MEET WITH A PATIENT SERVICES ASSISTOR** Otherwise, services will be rendered at the full charge.

Employed Person	Company Name	Income (Before Taxes)	Paid how often? (Check One)
		$	☐ Weekly ☐ 2 times per month ☐ Monthly ☐ Every 2 weeks
		$	☐ Weekly ☐ 2 times per month ☐ Monthly ☐ Every 2 weeks
Other sources of income:	Alimony $	TANF $	Pension/Retirement $
Child Support $	Disability $	S.S.I. $	Social Security $
Unemployment $	Other $	Other $	Other $

Household Information: List ALL individuals in household, including the head of household.

Name	Date of Birth	Relationship	Age	Income	Employed
1.					Yes/No
2.					Yes/No
3.					Yes/No
4.					Yes/No

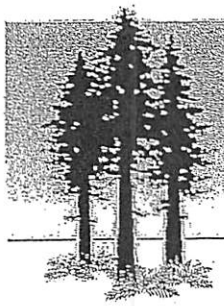
***** List additional Persons on Back of Application***

Applicant Signature_____ **Date** ____/___/____

FOR OFFICE USE ONLY

- ○ Patient has been approved for sliding-fee scale: A ☐ B ☐ C ☐ D ☐ E ☐
- ○ Patient applied for Medi-Cal or Covered CA (circle program) App Date: _____
- ○ Patient denied Medi-Cal coverage (copy of denial attached)
- ○ Patient has met Share-of-Cost or Deductible and is not eligible for the sliding-fee program.
- ○ Patient's income is too high to qualify for the sliding-fee program.
- ○ Patient declined to provide income information or refused to complete the eligibility form.
- ○ Patient has declined the sliding fee

Staff Signature_____ _____



Redwoods Rural HEALTH CENTER

Family Health Care

Silver Diamine Fluoride Consent Form

This is to inform you the patient/guardian/parent of _____ will be receiving treatment with Silver Diamine Fluoride (SDF) to stop and eradicate the decay process. This treatment is a conservative approach for the treatment of active decay.
This is a simple procedure that requires the teeth/tooth to be isolated with cotton rolls, dried with air and a small amount of silver diamine fluoride applied with a micro brush. A cavity will be indicated by turning dark, this is a positive indication that the treatment is effective. If the SDF contacts skin and/or gum tissue they will also become discolored temporarily. If any tooth treated has a restoration, it may discolor. Demineralized teeth with white lesions may also discolor.

Do not eat, drink or brush for one hour, and refrain from brushing for 24 hours after treatment

The above treatment has been explained to me to my satisfaction and I have been given an opportunity to ask any questions regarding the nature and purpose. I have read this form, and understand the treatment, the risks, benefits and alternate treatments. I give my consent to have Silver Diamine Fluoride on:

Patients Name:

_____

No warranty or guarantee has been made as to the result or cure. It has been explained to me and i understand the consequences which may affect my child's health if dental treatment is not performed.

_____

Printed name of Parent/Legal Guardian Date

_____

Signature of Parent/Legal Guardian Date

_____

Witness Date

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Medical (707) 923-2783 • Dental (707) 923-4313 • Fax: 707-923-2543

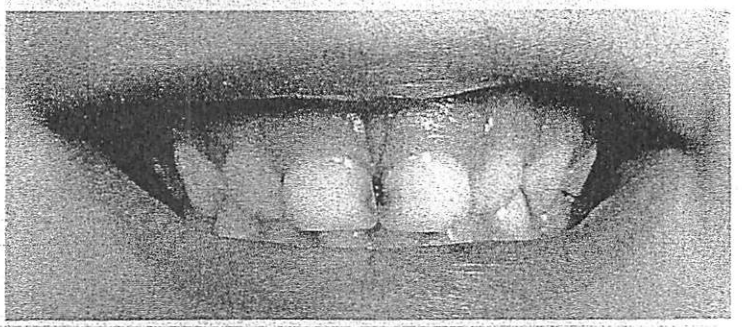
Silver Diamine Fluoride 38% - SMART

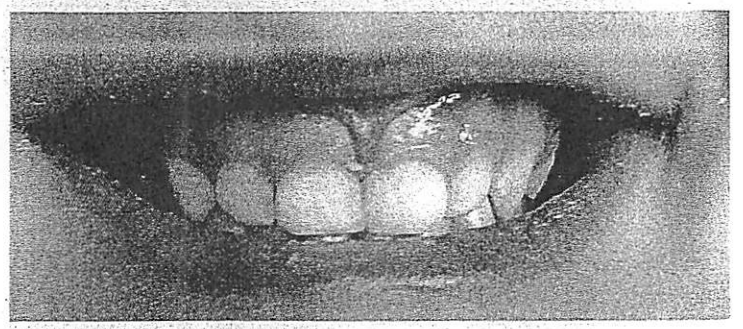
Silver Modified Atraumatic Restorative Treatment (SMART) For Enhanced Esthetics

The before/after sets of images show teeth treated with silver diamine fluoride and then covered with glass ionomer. These materials can be placed in minutes without the need for drills, adhesives or instruments. SMART restorations will provide sufficient masking for most cases.

In situations where esthetics are paramount, especially for permanent dentition, polish away discoloration along the margins, then cover the remaining discoloration with a "sandwich" of opaque glass ionomer followed by a composite material.

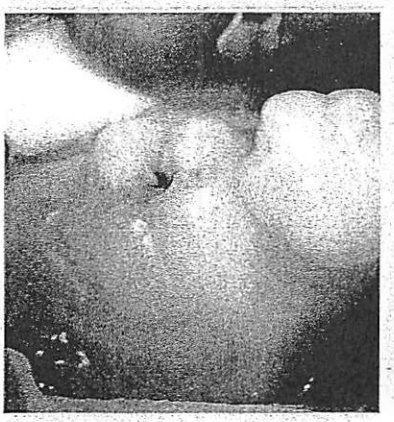
SMART with Nitrous Oxide, but No Local Anesthesia





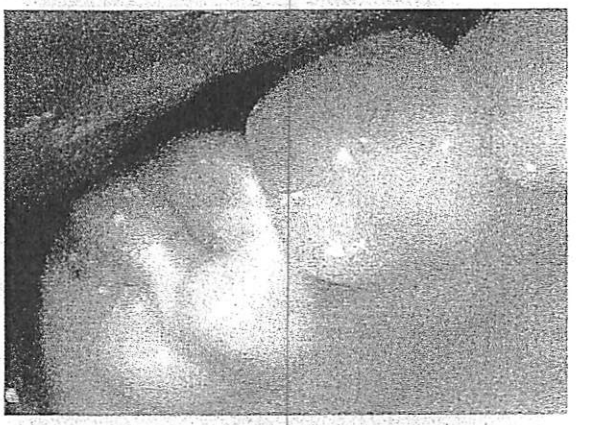
Photos courtesy of Dr. Jeanette MacLean

SMART With No Tooth Structure Removal

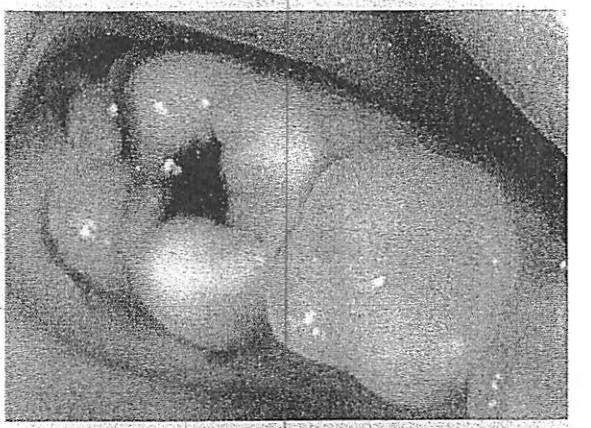


Photos courtesy of Dr. Jeanette MacLean

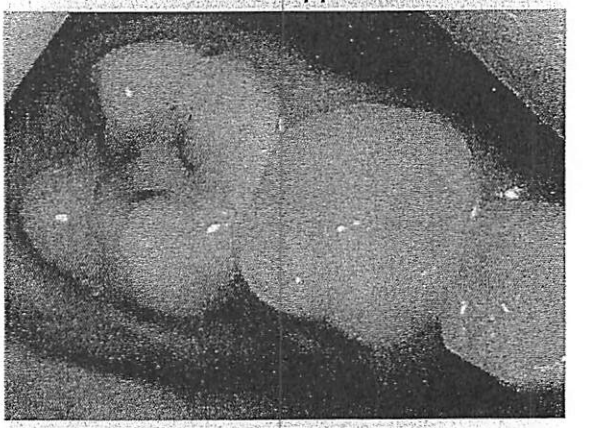
Hypoplastic Molar SMART Application



Before



After SDF Application



Glass Ionomer Placed With No Tooth Structure Removal

Photos courtesy of Dr. Jeanette MacLean

elevate™ ORAL CARE

Redwoods Rural HEALTH CENTER

Family Health Care

PATIENT CENTERED HEALTH HOME (PCHH) Patient / Provider Agreement

---------- *Slide 1*----------

Patient name: _____ **Birth date:** _____

Good communication between patients and physicians is the key to better outcomes. RRHC's Team is committed to providing you the highest quality medical care. This can best be accomplished by a clear understanding about our responsibilities to you, and your rights and responsibilities as a patient in our practice.

Our Responsibilities to You:

- Respect you as an individual — we will not make judgments based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation or genetic information
- Respect your privacy — your medical information will not be shared with anyone else unless you give permission or as required by law
- Provide personalized treatment and advice based on current medical evidence — we respect your right to information and will discuss appropriate or medically necessary treatment options
- Keep you informed of test results, upcoming appointments, health education materials, and community resources
- Manage & improve your health status, including well child/preventive care, treatment for acute and chronic diseases, tools for health maintenance, and monitoring your progress on health goals
- Provide you timely access to care in our practice, as well as facilitate timely access to specialists, diagnostic, services, and other care as needed

What We Ask of You:

- Ask questions, share your feelings, and be part of your care
- Be honest your medication, health history, symptoms, and other important information about your health
- Request that any other healthcare provider I see send my doctor a report, copies of lab work, test results, and x-rays
- Tell the practitioner about any changes in your health and well-being
- Know my insurance and what it covers, or ask one of RRHC's Patient Services Assistors for clarification

Redwoods Rural HEALTH CENTER

Family Health Care

PATIENT CENTERED HEALTH HOME (PCHH) Patient / Provider Agreement

---------- *Slide 2*----------

- Actively participate in developing a personal action plan - make healthy decisions about your daily habits and lifestyle
- Take medicine as ordered and follow your care plan and provider's advice — if you are unwilling or unable to do so, be honest with the practitioner
- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible
- Call your RRHC provider first with all problems, including specialty care needs, unless there is a medical emergency
- End every visit with a clear understanding of the practitioner's expectations and your treatment goals and future plans
- Provide RRHC with feedback on how we can improve

PLEASE NOTE: Our office is open 8:00 a.m. 5:30 p.m. Monday through Friday for same day appointments that maybe needed. When the office is closed, we have an answering service that will contact RRHC's on-call provider to address medical issues that cannot wait until regular office hours.

Urgent or Emergent Care: Please attempt to call me before going to an after-hours urgent care facility or to an emergency room unless you believe you have a serious problem requiring immediate medical attention.

By signing below, you indicate that you have read this document, and that it is your wish to join our medical home and to do your best to abide by the statements listed above. This is not a legally binding contract, but is intended to provide a framework upon which we can build a relationship that will allow you to maximize your health status in a comfortable and welcoming environment.

Patient, Parent or Guardian signature: _____

RRHC Provider signature: _____

Date: _____

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