Welcome to Community Health Alliance

Thank you for choosing Community Health Alliance. We are proud to serve as your patient centered medical home to provide and coordinate the health care services you need. A patient centered medical home is a team-based approach to providing health care with the patient as the central focus. As our patient, you will have access to a skilled team of medical, dental, and behavioral health professionals, low-cost pharmacies, prescription food pantries, supportive services, and programs. At Community Health Alliance, our goal is to provide you with the health care that you deserve.

Patient Centered Medical Home (PCMH)

As part of our ongoing effort to ensure we are providing the highest quality health care in the region, we have sought and have received recognition from the National Committee for Quality Assurance (NCQA), a non-profit organization dedicated to improving health care quality. A patient centered medical home (PCMH) is a team providing you evidence-based, personalized health care. "Patient-Centered" is a formal way of saying that you are the focus of your health care. Your team consists of your health care providers, your support system, and the leader of the team: YOU. As an active member of your PCMH, you will have a chance to explain things that are important to you. You and your health care team will work together to create a care plan that:

1. Is created just for you.
2. Connects you with your health care team.
3. Is coordinated with other health care providers.
4. Supports you every step of the way (even if that means getting help from other doctors).

Choosing a Provider

When you establish care with us, you will be asked to choose a Primary Care Provider that you will see when you get care at the health center. You are given a choice of Providers who are available according to your preferences and the health center location. Your health care team will get to know you, your history, your health care needs, and you will know who to contact when you have questions or need help.

After Hours Assistance

If you are a current patient and need to reach your provider urgently, outside of regular office hours, you may reach our after-hours line by calling 775-329-6300. Our answering service will put you in touch with the on-call provider. If you are experiencing a medical emergency, please call 911.

If you are admitted to the Hospital

If you are admitted to the hospital, please tell the hospital staff that we are your Primary Care Provider. It is important that we know you are in the hospital, so please ask them to notify us. Your care will be overseen by the hospital doctor while you are there, but your Primary Care Provider may be contacted to provide information about the care you received from us in the past. When hospital staff are talking about discharging you, be sure to contact us to schedule a follow-up visit.

Accessible Hours of Operation & Locations

Our Health Centers are open Monday-Friday. For a complete list of hours of operation and locations, please visit our website at www.chanevada.org

Services

We provide a comprehensive range of services that include:

Primacy Care & Family Medicine

- Immunizations and Health Screenings
- Treatment of acute and chronic conditions
- Sick Visits
- Lab Services
- Health care for the Homeless

Women's & Reproductive Health

- Birth Control
- Breast Care
- Cancer Screenings & Prevention
- HIV Testing & Screening
- Pregnancy Services
- Prenatal Care and Post Partum Care
- STD Testing, Treatment & Vaccines

Pediatric Care

- Well baby and child physicals
- Immunizations
- Sick visits

Dental

- Cleanings, Oral Exams, X-Rays
- Dental Sealants
- Fillings
- Crowns
- Emergency Dental Services

Behavioral Health

- Counseling for couples, individuals, families, children, and adolescents
- Assessment and coordination
- Substance Use Treatment
- Telehealth

Low-Cost Pharmacies

When it comes to prescriptions and immunizations, convenience is key. That's why we feature one-stop, low-cost pharmacies at three of our locations. Pick up your medications immediately after a medical or dental appointment or register for free delivery within 20 miles of your health center. Our team of friendly Pharmacists is here to help you manage your medications, as well as provide low or no-cost immunization services for your entire family.

If you are having trouble obtaining your medication at any local pharmacy, you can transfer your medications to any of our in-house pharmacies.

Programs

Women, Infants, and Children's (WIC)

We provide education, breastfeeding support services, supplemental nutritious foods and referrals to health and social services to pregnant, breastfeeding, and postpartum women, infants, and children under the age of 5 who live in Nevada. We also offer additional one-on-one support, monthly virtual support groups, and can provide internal and external referrals to expert breastfeeding and lactation care.

Prescription Food Pantries

Our Prescription Food Pantries provide free, nutrient-rich food to those who lack consistent access to enough food for an active, healthy life. Receiving food from our pantries is simple. The only requirement is to be a patient at Community Health Alliance.

Community Health Worker Program

Community Health Alliance's Community Health Workers are trained public health educators improving healthcare delivery with integrated and coordinated services across the continuum of health. Our Community Health Worker (CHW) program is available to assist patients with social drivers of health by connecting patients to resources and assisting with chronic disease management and prevention. Social Drivers of Health (SDOH) are the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age.

Billing & Payment Information

Don't have insurance?

Community Health Alliance provides services to all individuals whether you have insurance or not. We offer a variety of self-pay options for those who are uninsured or underinsured that is based off family size & income, and always work with you to ensure you receive affordable and quality care.

How do I pay for my visit?

Community Health Alliance offers low-cost, discounted, and flexible payment options for uninsured and underinsured patients. We participate in most insurance plans, including Medicaid and Medicare. Copay is required when you check in for your appointment. Community Health Alliance accepts cash, check, Visa, or MasterCard. We never deny care to anyone based on ability to pay.

Insurance Enrollment Assistance

Everyone who comes into our health centers for healthcare services is screened for health insurance eligibility, including Medicaid, Medicare, and Supplemental Nutrition Assistance Program (SNAP). Our Healthcare Access Specialists walk you through the process so that you, and your entire family, can have peace of mind when it comes to protecting your health.

Our team is available throughout the year to help you answer any questions that may arise about your health insurance status. Is open enrollment over and are you experiencing a qualifying life event such as adding a new member to the family, or have you recently lost health insurance coverage? Not a problem. We can help you navigate life's curveballs and ensure you have proper health coverage.

Patient Portal

The Community Health Alliance Patient Portal gives you safe and secure access to your personal health information records from anywhere with an internet connection. Features include:

- Send and receive messages with your health care team
- Access your health records
- Request appointments
- View latest test results
- Update your contact information

Interested in signing up for the Patient Portal?

Please let one of our staff members know!

COMMUNITY HEALTH ALLIANCE

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:	DOB:_____/_____/_____ SSN:_____

Street Address:	City:	State:	Zip:

Cell Phone: ☐ Preferred ☐Do not send text messages	Home Phone: ☐ Preferred	Email: ☐ Declined	Preferred Name:

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

Student Status: ☐ Full Time ☐ Part Time ☐ Not a Student

Race Group: ☐ White ☐ Black or African American ☐ Asian ☐ Native America/Alaskan ☐ Hawaiian or Other Pacific Islander ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Guamanian or Chamorro ☐ Samoan ☐ Vietnamese ☐ Declined to Specify

Ethnic Group:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Chicano ☐ Cuban ☐ Mexican
☐ Mexican American ☐ Puerto Rican
☐ Declined to Specify

Preferred Language: ☐ English ☐ Spanish ☐ Tagalog Other_____	Hearing Impaired: ☐ Yes ☐No Disabled: ☐ Yes ☐No Need Interpreter: ☐ Yes ☐ No	Visual Impaired: ☐ Yes ☐ No Need Accommodations: ☐ Yes ☐ No

Sex at Birth: ☐ Male ☐ Female Preferred Pronoun ☐ She/Her ☐ He/Him ☐ They/Them	What is your current gender identity? (please check all that apply) ☐ Male ☐ Female ☐ Genderqueer ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer Other, please specify:	Sexual Orientation: ☐ Straight or Heterosexual ☐ Lesbian, Gay, Homosexual ☐ Bisexual ☐ Unknown ☐ Decline to answer Other/Something else, Specify:

Employment Status: ☐ Employed Full Time ☐ Employed Part-Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ On Active Military Duty

☐ Migratory Agricultural Worker
☐ Seasonal Agricultural Worker

Emergency contact: **MUST PROVIDE EMERGENCY CONTACT OTHER THAN SELF:**	Phone Number:	Relationship:

Homeless: Are you Homeless? ☐ Yes ☐ No If yes, please choose one option below:
☐ Street ☐ Doubling Up ☐ Homeless Shelter ☐ Transitional Housing ☐ Permanent Supportive Housing* ☐ Other (e.g. weekly rental)
*Housing with Supportive Services and no time restrictions

Are you a Veteran? ☐ Yes ☐ No

COMMUNITY HEALTH ALLIANCE

As a Health Center that receives federal funding, we are required to collect this information. Our funding makes sure we can serve anyone who needs our care. All answers are confidential. We appreciate your help!

Number of Persons in the Family: _____
Total Amount of Household Income: _____ ☐ ***Monthly*** ☐ ***Annually***

☐ ***I choose not to disclose my family size and income***

GUARDIAN/PARENT OR RESPONSIBLE PARTY				
Last Name:	First:	Middle Initial:	☐ Male ☐ Female	Marital Status:
Last Name:	First:	Middle Initial:	☐ Male ☐ Female	Marital Status:
Address (if different):		City:	State:	Zip:
Home Phone:	Cell Phone:		Work Phone:	
Your Date of Birth:	Relationship to Patient: ☐ Spouse ☐ Parent ☐ Guardian Other:_____			
Financially Responsible: ☐ **Self** ☐ **Parent** ☐ **Guardian** ☐ **Power of Attorney**			**Document on File:** ☐ Yes ☐ No	

COMMUNITY HEALTH ALLIANCE

PRIMARY MEDICAL INSURANCE		
Primary Medical Insurance Company:		Insurance ID Number:
Insurance Policy Holder's Name (if different)	Relationship to Patient:	Insurance Group Number:
Insured Birth Date:	Insured Social Security Number:	Primary Phone:
Employer:		Employer Phone:

SECONDARY MEDICAL INSURANCE		
Secondary Insurance Company:		Insurance ID Number:
Insurance Policy Holder's Name (if different)	Relationship to Patient:	Insurance Group Number:
Birth Date:		Primary Phone:
Employer:		Employer Phone:
Chart Number:	CHA Staff (Print Name):	Date:

DENTAL INSURANCE		
Dental Insurance Company/Carrier:		Dental Insurance ID Number:
Dental Insurance Policy Holder's Name (if different)	Relationship to Patient:	Dental Insurance Group Number:
Insured Birth Date:	Insured Social Security Number:	Primary Phone:
Employer:		Employer Phone:

COMMUNITY HEALTH ALLIANCE

Consent for Treatment I voluntarily consent and authorize for such care and treatments including but not limited to; Physical examination, diagnostic tests, medical procedures, behavioral health consult, and medications by employees and authorized agents of Community Health Alliance including; all affiliated physicians, dentists, advance practice registered nurse, physician assistants, licensed behavioral health/substance abuse professionals, pharmacists, nursing staff, and ancillary providers as may be considered necessary or advisable in their professional judgement. I am aware that the practice of medicine is not an exact science and further acknowledge that no guarantees have been made regarding the effect such treatments may have on any medical conditions. I understand that a pharmacist may initiate, modify or discontinue any medication in accordance to a collaborative practice agreement; and I am aware that a pharmacist is not a physician, osteopathic physician, advanced practice registered nurse or physician assistant.

Right to Refuse Treatment I understand that I have the right to make informed decisions regarding all care and treatments. I understand that I may ask healthcare professionals to explain anything that is not understood. This includes the right to refuse any treatments.

Telehealth Services Certain healthcare services may be provided to me by a telehealth or telecommunication system that allows my provider to view my condition and provide me with treatment directly when I am off site. I am entitled to receive a description of the risks, benefits, and consequences of telehealth services and a description of my privacy rights as they relate to telehealth services. I have the right to terminate telehealth services at any time. I may access copies of all transmitted health information. My information will not be disseminated to other entities without my consent. If treatment is provided using an asynchronous system, I have the right to request and receive interactive communication with my provider within 30 days of my request.

Patient Portal I am aware that by providing Community Health Alliance with my current email address I will have access to my secure medical chart via the Patient Portal. I will be able to access upcoming appointments, lab results, diagnostic imaging results, non-urgent medical questions and more.

Behavioral Health Treatment: I understand that should I choose to pursue behavioral health services at Community Health Alliance, my initial consult will be conducted at a scheduled appointment with a licensed behavioral health professional. If insured, my health insurance will be billed for the BH consult session accordingly. I consent to the initial behavioral health consult and/or telehealth consult.

Consent for Billing All co-payments, deposits, and sliding fees are due and payable at the time of service. I assign all insurance payments to be made directly to Community Health Alliance. This authorization and assignment is permanent unless I exercise my right to revoke authorization and assignment with my written notice at any given time. I understand that it is my responsibility to confirm with my insurance carrier the participating provider status of Community Health Alliance. I will be responsible for any charges incurred that my insurance does not cover. I hereby authorize Community Health Alliance to release information necessary to file and/or process a claim with my insurance company.

Patient Rights You have the right to receive considerate and respectful care, you have the right to participate in your healthcare, and you have the right of resolutions of issues or complains. *Please review patient welcome packet for more information.*

Patient Responsibilities Please provide complete and accurate information to the best of your ability regarding your health, follow your treatment plan or discharge of treatment, please ask for further instructions if you do not understand your treatment plan, inform us if you have a durable power of attorney, provide us with accurate financial information, keep your appointments, maintain respectful communications, refill prescriptions on a timely manner (No prescriptions will be filled early). *Please review welcome packet for more information or visit our website chanevada.org*

Chronic Pain Management Policy Community Health Alliance does not provide chronic pain management with opiate-based medication for new patients nor will established patients be started on chronic pain management services. All patients must sign an acknowledgment of this policy when they register. If you have questions about this policy, please speak to the Health Center Manager before signing.

Acute Pain Controlled Substance Policy CHA may treat a patient for acute pain at the discretion of the treatment provider. You must inform your provider if you are taking pain medication from another provider. We reserve the right to terminate the medical provider/dentist- patient relationship.

Consent to Electronic Communication: I consent and authorize Community Health Alliance and its related entities, agents, contractors, including but not limited to schedulers, billing, and other staff to use automated telephone dialing systems, SMS text messaging, and electronic mail to (1) provide messages (including pre-recorded messages or text messages) to me about my account, payment due dates, missed payments, information for or related to medical goods and/or services provided, exchange information, changes to health care law, health care coverage, care follow-up, and other healthcare information or (2) provide messages (including pre-recorded messages) during a call or via text message that delivers a 'health care' message made by, or on behalf or, a 'covered entity' or its 'business associate' as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103. I understand that I may opt out by calling Community Health Alliance.

Missed and Late Appointment Policy As a patient, it is your responsibility to keep all scheduled appointments. Rescheduling will cause a delay in your care. We request notice of any cancellation at least 24 hours prior to your appointment or earlier if possible. A patient who arrives at their scheduled appointment within ten (10) minutes after their scheduled appointment will be considered an acceptable late arrival, and be seen that day. A missed appointment is a scheduled appointment, which the patient does not show up for and does not contact us to cancel the appointment prior to the scheduled appointment time. A patient who arrives at their scheduled appointment eleven (11) minutes or more after their scheduled appointment start time is a non-acceptable late arrival and will not be seen, this will be considered a missed appointment.

The information I have provided is true and correct to the best of my knowledge. I have read and understand the above information and agree to comply with the terms above the services rendered by CHA.

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

_____ _____

Print Name Print Staff Name

COMMUNITY HEALTH ALLIANCE

Patient Rights and Responsibilities

You have the right to receive considerate and respectful care through:

- Maintaining your personal privacy and comfort, providing a safe and secure setting to receive care, free from all forms of abuse or harassment.
- Confidential handling of all communications and records pertaining to care. Medical records are only available to persons directly involved in your care and except to the extent allowed by law, are not released without your written permission.
- Being informed of the services available in this health center and the names and credentials of the personnel providing your care.
- Changing your provider if other qualified providers are available.
- Confidential Sexual and Reproductive Health Services

You have the right to actively participate in your healthcare by:

- Receiving information about your health status, the course of treatment in terms that you can understand.
- Reviewing your medical chart with the treating provider and to receive a thorough explanation of treatment, results of tests and procedures.
- Receiving information regarding rules and policies that apply to your conduct while a patient.
- Access to information contained in your medical records within a reasonable time frame (except in certain circumstances regulated by law).
- Participating in the planning of your care and treatment options, including the option of no treatment. You have the right to refuse medication and treatment.
- Being provided, to the degree known, an explanation of your complete medical/health condition, diagnosis, prognosis and recommended treatment, including the risk(s) of treatment or no treatment, alternatives and expected result(s).
- Receiving an explanation of your bill regardless of the source of payment, including available methods of payment, and if you are uninsured, information regarding our financial assistance program.

You have the right of resolution of issues or complaints:

- As a patient, you have rights to not be discriminated against because of age, race, religion, gender, sexual orientation, color, nationality, language, marital status, citizenship, veteran status, physical, mental, or intellectual disability, cultural, economic, educational background or the source of payment for services.
- You have the right to necessary interpretation services related to language and/or disability but need to inform staff of this accommodation need timely.
- You have the right to make suggestions, recommended changes in policies and services, voice grievances or make complaints to or about facility personnel without risk of reprisal. You may voice grievances or recommend changes directly with a supervisor, manager or your physician, on the patient satisfaction survey or by submitting a complaint form to the Compliance Officer. This form can be obtained from any health center staff. You may contact the Compliance Officer at 775.870.4312 to verbalize your complaint(s).

Each patient, and/or their designated representative, receiving services in this health center shall have the following responsibilities:

- To provide complete and accurate information to the best of your ability regarding your health, health complaints, past illnesses, hospitalizations, medications and allergies/sensitivities and other matters relating to your health care.
- To follow the treatment plan (including discharge instructions and follow-up appointments) prescribed by your provider and to notify your provider of any decision to not follow your treatment plan.
- Ask your provider if you do not understand your treatment plan.
- To read all permits and/or consents that you sign and to ask the staff or provider for clarification or help for anything you do not understand.
- To inform us if you have a durable power of attorney, an advance directive, a living will or any other directive and to provide a copy for our records.
- To provide accurate proof of your financial situation and accept financial responsibility for any charges not covered by your insurance or incurred based on our sliding fee scale; paying timely.
- To keep your appointments; if you cannot keep an appointment, let us know as soon as possible so another patient may have that appointment.
- Maintain respectful communications and interactions with your Community Health Alliance healthcare team members.
- Conduct yourself appropriately within Community Health Alliance facilities; you may not verbally or physically abuse personnel or property or make verbal threats or use threatening (hostile/aggressive) language.
- Use appropriate words without vulgar or threatening language.
- Refrain from coming to appointments intoxicated.

680 South Rock Blvd
Reno, NV 89502
www.chanevada.org
Todd Johnson
HIPAA Privacy Officer
tjohnson@chanevada.org
775-329-6300 ext. 387

Community Health Alliance

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get (access) an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 10 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct (amend) health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
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 say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • 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 share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a facility directory • Contact you for fundraising efforts If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	**Example:** A doctor treating you for an injury asks another doctor about your overall health condition.
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	**Example:** We use health information about you to manage your treatment and services.
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	**Example:** We give information about you to your health insurance plan so it will pay for your services.

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you 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

Do research	• We can use or share your information for health research.
Comply with the law	• We will share 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're complying with federal privacy law and 42 CFR Part 2 Final Rule.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director Health	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' 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

Respond to lawsuits and legal actions	• We can share health info We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Behavioral Health/SUD Programs	• We are allowed to redisclose records in accordance with HIPAA regulations. • Substance Use Disorder (SUD) Records are restricted from use in testimony in civil, criminal, administrative and legislative proceedings against patients, without patient consent or a court order. • We require a separate patient consent for the use and disclosure of SUD counseling notes. A copy of the consent or a clear explanation of the scope of the consent must accompany each patient approved disclosure.

Reproductive Health	• We are prohibited from using or disclosing PHI for either of the following activities:
	  • To conduct a criminal, civil or administrative investigation into or impose criminal, civil, or administrative liability on any person for the act of seeking, obtaining, providing, or facilitating reproductive health care where health care is lawful under the circumstances in which it was provided.
	  • The identification of any person for the purpose of conducting such or imposing such liability.
	• We are prohibited from using or disclosing PHI if we have determined that the care was provided in a state where reproductive health is lawful by a licensed provider or that health care is protected, required or authorized by Federal law.
	• CHA is required, when it receives a request for PHI potentially related to reproductive health care, to obtain a signed attestation from the requestor that the use or disclosure is not for the prohibited purposes listed above. This reproductive health attestation requirement applies when the request is for PHI for any of the following:
	  • Health Oversight activities
	  • Judicial and administrative proceedings
	  • Law enforcement purposes
	  • Disclosure to coroners and medical examiners

We do not create or manage a facility directory.

We will not share any substance abuse treatment records without your written permission, unless required by NRS 484C or NRS 488.

CHA destroys patient health records after six years for inactive patients, unless the person is less than 23 years of age. Records for children and young adults are destroyed after the patient turns 29 years of age. Records for inactive patients covered by Medicare are retained for seven years as covered in 42 CFR 424.516(f).

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our offices, and on our web site.

Effective Date of Notice is October 1, 2024.

This Notice of Privacy Practices applies to the following organizations.

This notice applies to all facilities operated by Community Health Alliance.

Todd Johnson
HIPAA Privacy Officer
tjohnson@chanevada.org
775-329-6300 ext 387

COMMUNITY HEALTH ALLIANCE

COMMUNITY HEALTH ALLIANCE
ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office at (775) 870-4312 or by visiting our website at www.chanevada.org.

You have the right to request that we restrict how protected information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke the Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Community Health Alliance provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and other state and federal laws related to the protection of PHI.

You the undersigned understand that:
• Protected health information may be disclosed or used for treatment, payment, health care operations, or as required by law.
• Community Health Alliance has a Notice of Privacy Practices and you have had the opportunity to review this notice prior to signing this acknowledgement.
• Community Health Alliance reserves the right to change the Notice of Privacy Practices.
• The patient has the right to request restrictions to the uses of their information but Community Health Alliance does not have to agree to those restrictions.
• The patient may revoke this Consent in writing at any time and full disclosures will then cease.
• Community Health Alliance may condition receipt of treatment upon the execution of this consent.

Voicemail/Text Messages:

- Extended Voicemail and Text Messages to include information on upcoming appointments, referrals, lab results, imaging results, preventative services (Due for pap, CRC, etc.), forms ready to be picked up; typically would not have to call us back.
- ☐ I want to receive extended voicemail and text messages at the following number _____
- ☐ I do not wish to receive voicemails and text messages from Community Health Alliance .

Mail Correspondence:

- I authorize confidential mail correspondence to be sent to my home: ☐ Yes ☐ No

I have received a copy of the Notice of Privacy Practices. I further understand that I can request an additional copy if need be and I can contact the Privacy Officer at (775) 870-4312, if I have questions or concerns.

_____
Name of Patient/Client (print)

_____ _____
Signature of Patient and or/ Client Representative Date
(Required if Patient/Client is a minor or an adult who is unable to sign this form)

_____
Relationship of Representative to Patient/Client (Print Name)

COMMUNITY HEALTH ALLIANCE

Authorization to Share Privacy Information

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), Community Health Alliance is required to keep your health information confidential and protected. You have the right to restrict family members or other persons from accessing your health information.

We are aware that many of our patients do not wish to restrict their spouse, family member or other person(s) from having access to their health information. In an effort to comply with HIPAA Regulations, and to avoid inconveniences for our patients, we are asking that you please complete this form.

If at any time you wish to change any of the information on this form, please notify our office in writing, we will honor your request.

Please list the family members or other persons, if any, who we may inform about your general medical condition, diagnosis, appointments, test results, or other health care information (including treatment, payment and procedures). **You are not required to list anyone. However, if you do, you are authorizing that person to have access to your medical and/or payment information.**

Patient's Full Name: _____ Phone Number: _____

Patient's Date of Birth: _____

Please mark the type of access you would like them to have:

Full Name: _____ Relationship: _____

☐ Appointment Information ☐ Billing Information ☐ Detailed Medical Information ☐ Ability to Authorize Release of Health Care Records to a Covered Entity

Full Name: _____ Relationship: _____

☐ Appointment Information ☐ Billing Information ☐ Detailed Medical Information ☐ Ability to Authorize Release of Health Care Records to a Covered Entity

Full Name: _____ Relationship: _____

☐ Appointment Information ☐ Billing Information ☐ Detailed Medical Information ☐ Ability to Authorize Release of Health Care Records to a Covered Entity

This authorization has no expiration date. It shall be termed when withdrawn in writing or an updated form has been completed.

Patient/Guardian Signature: _____ Date: _____

CONSENT FOR HEALTH SERVICES/TREATMENT OF A MINOR

THE UNDERSIGNED, DULY AUTHORIZED: ☐ **Custodial Parent** ☐ **Legal Guardian** (Check One)
does hereby give this written consent to Community Health Alliance to provide the necessary health care services including (Initial each one):

Primary Health Care	☐ Yes ☐ No
Health Education	☐ Yes ☐ No
Immunizations	☐ Yes ☐ No
Dental Health Care Services	☐ Yes ☐ No
Mental Health Services	☐ Yes ☐ No
Sex Education and Counseling	☐ Yes ☐ No
Screening for Pregnancy	☐ Yes ☐ No

to the following minor child: _____ Child's Date of Birth: _____
Print Child's Name Clearly

Consent is given for (Initial one) (1) the date of service only: ☐ _____; or, (2) ☐ in perpetuity (until Consent is withdrawn in writing provided to CHA).

In giving this consent, the undersigned hereby confirms the legal responsibility for making health care decisions for the aforementioned minor and can produce written verification if needed for such authority.

If the undersigned is unable to accompany the minor child to an appointment for any of the above initialed health care services, Community Health Alliance (CHA) shall attempt to contact the parent/guardian by phone to receive specific consent for a specific health care service. Alternatively, the undersigned may complete a CHA authorization for third party consent to treatment of minor form for each individual designated to act as the undersigned in their absence.

By signing this consent, the undersigned agrees to the terms and conditions regarding the payment of services for this minor child. The undersigned acknowledges receiving the **Notice of Privacy Practices** and acknowledgment, as explained in the **Patient Welcome Packet**, the **Patient Rights**, the **Registration Form** and the **New Patient Packet for Pediatrics**.

The undersigned has been notified and understands that he/she may withdraw consent at any time for any minor patient that is not emancipated and that a request to withdraw consent must be in writing and will be effective upon receipt by Community Health Alliance.

_____ _____ _____ _____
Parent/Guardian Signature **Date** **Parent/Guardian's Printed Name** **Initials**

Phone Number: (___) _____ **Alternate Phone Number: (___) _____**

IF THIS FORM WAS COMPLETED BY A PARENT AT HOME AND NOT COMPLETED AT A CHA HEALTH CENTER, IT MUST BE WITNESSED.

_____ _____ _____ **(___)**_____
Witness Signature **Date** **Witness Relationship** **Phone Number**

COMMUNITY HEALTH ALLIANCE

Authorization for Third Party to Consent to Treatment of Minor

I am the
____Parent
____Guardian
____Other person having legal custody_____
(Describe legal relationship and provide documentation)
of _____, a minor.
(Print Name of Minor)
I hereby authorize _____, to act as my agent to consent to all health care
(Print Name of Agent)
services which are recommended by, and delivered by any licensed provider at Community Health Alliance, whether such diagnosis, treatment or transport/referral for hospital care is required.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or transport/referral for hospital care being required, but is given to provide authority to the above-named agent to give consent to any and all such diagnosis, treatment, or transport/referral for hospital care which a licensed provider, from Community Health Alliance, recommends.

I have carefully read and fully understand this consent and agreement. I have received a copy of this consent/agreement and am duly authorized to execute the above, and I accept the terms as described. I understand this consent/agreement is effective until revoked in writing.

I acknowledge that I have the right to revoke these authorizations at any time, (which may be in writing, in person, or by certified mail to the provider at Community Health Alliance, c/o Compliance Officer, 680 S. Rock Blvd., Reno, NV 89502). The revocation will be effective only upon receipt, except to the extent that the Provider has acted in reliance on the authorization.

Signature: _____ Date/Time: _____
(Parent, guardian, other person above having legal custody)

Print Name: _____
(Parent, guardian, other person above having legal custody)

Witness to Signature: _____ Date/Time: _____

Print MINOR's Name: _____ Date of Birth: _____

_____ Copy given to Agent _____ Consent scanned in Minor's chart

REVOKE AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR
I hereby revoke this authorization for third party consent to treatment of said minor.

Signature: _____ Date/Time: _____
(Parent, guardian, other person above having legal custody)

_____ Copy given to Agent _____ Consent scanned in Minor's chart

COMMUNITY HEALTH ALLIANCE

Patient Consent Form

For Electronic Exchange of Individual Health Information

Details about patient information on HealtHIE Nevada and the consent process:

1. How your information will be used and who can access it: When you provide consent, only HealtHIE Nevada participants (such as doctors, hospitals, laboratories, radiology centers and pharmacies), will have access to your health information. It can only be used to:
    - Provide you with medical treatment and related services.
    - Evaluate and improve the quality of medical care provided to all patients, using de-identified health information.

2. Types of information included and where it comes from: The information about you comes from participating organizations that have provided you with medical care. These may include hospitals, physicians, pharmacies, clinical laboratories and other health care organizations. Your health records may include a history of present illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medications your doctor has prescribed. This may include information created before the date of this Consent Form. This information may relate to sensitive health conditions, including but not limited to:

-Alcohol or drug use problems	-HIV/AIDS	-Birth Control and Family Planning
-Genetic (inherited) diseases or teste	-Mental Health conditions	-Sexually Transmitted Infections

3. Improper access or disclosure of your information: Electronic information about you may be disclosed by a participating doctor to others only to the extent permitted by Nevada State Law. If at any time you suspect that someone who should not have seen or received information about you has done so, you should notify your doctor.

4. Effective period: Your consent becomes effective upon signing this form and will remain in effect until the day you revoke it or HealtHIE Nevada ceases to conduct business.

5. Revoking your consent: You may revoke your consent at any time by signing a new consent form and giving it to your doctor. These forms are available at your doctor's office, or by calling 855-484-3443. Changes to your consent status may take 24-48 hours to become active in the system.

   Note: Organizations that access your health information through HealtHIE Nevada while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

6. How your information is protected: Federal and state laws and regulations protect your health information. HIPPA, the Healthcare Insurance Portability and Accountability Act of 1996, is the federal law that protects your medical records and limits who can look at and receive your health information, including electronic health information. HIPPA's protections were further strengthened by another federal law, the HITECH Act of 2009, which may impose severe financial fines on anyone who violates your medical privacy rights. All health information made available on the HIE, including your medical information, is encrypted to federal standards and is accessible only as allowed by Nevada State Law (NRS 439.590). In addition, you doctor must provide you with a Notice of Privacy Practices, which describes how he or she uses and protects your medical information.

COMMUNITY
HEALTH
ALLIANCE

Patient Consent Form for Electronic Exchange of Individual Health Information

Nevada Medicaid Patients: PLEASE READ. Nevada law mandates that "a person who is a recipient of Medicaid or insurance pursuant to the Children's Health Insurance Program may not opt out of having his or her individually identifiable health information disclosed electronically" (NRS 439.539). When a patient is no longer a Medicaid recipient, it is her/his responsibility to change their consent choice, if they choose to do so. Please sign below to indicate your acknowledgement.

By signing this consent form you agree for all HIE participants to access all of your electronic health information (including sensitive information) in connection with providing you any health care services, including emergency care. Unless you choose not to participate or opt-out. If you choose to opt-out, physicians will not be able to look for your records in Health Information Exchange, or have the most recent information about you, which may adversely affect your care. If you do not want to participate in Health Information Exchange, you must complete, sign and submit the Opt-Out Form. By completing the Opt-Out Form, you are only opting out of Health Information Exchange. Your records can still be shared directly between your health care providers outside of Health Information Exchange using traditional methods (fax, mail, phone). If you choose to opt-out of Health Information Exchange, we will still continue to provide you with health care treatment in our facilities.

_____ _____

Signature of patient or authorized representative Date

If I sign this form as the patient's authorized representative, I understand that all references in this form to "I," "me" or "my" refer to the patient.

_____ _____ _____

Name of authorized representative (printed) Relationship Date

Community Health Alliance
Sliding Fee Scale Discount Program Application

As a Federally Qualified Health Center, we are pleased to offer the Sliding Fee Discount Application to all patients at all health centers for Medical/Behavioral Health/Dental/Reproductive/Pharmacy services. If you apply and are determined to be eligible, you may qualify for a discount. We may be able to assist you by applying our sliding fee discount to your co-pay and deductibles if your insurance allows. If you choose to apply for the Sliding Fee Scale, please complete this form in its entirety.

If you choose not to apply Please print name, date of birth, sign and date, and check mark the box indicating you are declining the application. Upon declining, you will be responsible to pay for your services at Community Health Alliance.

Patient Name:_____
Date of Birth: _____

Number of Persons in the Family:_____

NAME OF DEPENDENTS	DOB	AGE	NAME OF DEPENDENTS	DOB	AGE

Total Amount of Household Income:_____ (Weekly/Bi-Weekly/Monthly/Annually)

Unable to provide Income Verification ☐
Income Verification Attached ☐
Declined Sliding Fee Scale Discount Program ☐

(Community Health Alliance's nominal fee will be charged regardless of income qualification)

Eligibility for Sliding Fee Discount Program is based on family size and income only.

This form will be valid for one year; upon expiration, a new form will have to be completed.

I certify that the information I have given on this form is true and correct to the best of my knowledge.

_____ _____
Signature of Patient or Parent (if patient is a minor) Date

CHA: Employee name: _____Date: _____
For Office Use Only: ☐ Did not qualify – scan page into patient documents

CHA SERVICES:

( ) B
( ) C
( ) D
( ) E
( ) F *

*Only qualifies for RH Slide

COMMUNITY HEALTH ALLIANCE

HEALTH HISTORY 12-17 YRS

Patient Name:	DOB:	Date:
Main reason for today's visit:		
Where were you getting your MEDICAL care before? (Previous doctor/PCP):		

Please list (or show us your own printed record) all prescription and non-prescription medications, vitamins, home remedies, birth control pill, herbs, inhalers, etc.

☐ **TAKE NO MEDICATIONS** ☐ History of Blood thinning medications ☐ Current/Past Chemo Therapy

☐ History of steroid therapy ☐ History of aspirin therapy ☐ History of Osteoporosis medication

MEDICATIONS	DOSE(e.g. mg/pill)	HOW MANY TIMES PER DAY?	MEDICATIONS	DOSE(e.g. mg/pill)	HOW MANY TIMES PER DAY?

ALLEGIES OR INTOLERANCE TO MEDICATIONS:

Are you allergic to the following? DK (Don't know) ☐ **None**

Latex ☐ Yes ☐ No ☐ DK Metals ☐ Yes ☐ No ☐ DK Local anesthetic ☐ Yes ☐ No ☐ DK Iodine ☐ Yes ☐ No ☐ DK

Ibuprofen ☐ Yes ☐ No ☐ DK Sulfa/Sulfite ☐ Yes ☐ No ☐ DK Codeine ☐ Yes ☐ No ☐ DK Aspirin ☐ Yes ☐ No ☐ DK

Penicillin ☐ Yes ☐ No ☐ DK Other ANTIBIOTICS ☐ Yes ☐ No ☐ DK Other ☐ _____

PERSONAL MEDICAL HISTORY: Do you have now (current) or have had (past) any of the following conditions?

CONDITION	CURRENT	PAST	CONDITION	CURRENT	PAST
Alcohol/Drug abuse			Heart Disease		
Anxiety			Heart Valve Replacement		
Arthritis			High Blood Pressure		
Asthma/COPD/Lung Disease			High Cholesterol		
Bleeding disorder			HIV/AIDS		
Cancer breast			Joint replacement/ when		
Cancer Colon			Kidney Disease/Failure (chronic)		
Cancer Cervical			Liver Disease/Cirrhosis/Hepatitis		
Cancer other type (See below)			Osteoporosis (See below)		
Congenital Methemoglobinemia			Radiation Therapy		
Depression			Rheumatic Fever		
Diabetes			Seizure/Epilepsy		
Do you have active/latent Tuberculosis/TB			Sleep Apnea		
Gastroesophageal Reflux (heartburn/GERD)			Stroke		
Glaucoma			Thyroid Disease		

Surgical History including Sterilization (Hysterectomy, Tubal Ligation, Vasectomy) : (List date and type of surgery)

_____

_____

_____

If you have Osteoporosis:

Are you taking or scheduled to begin taking either of the following medications, Alendronate (Fosamax) or Risedronate (Actonel) for osteoporosis? □ Yes □ No

If you have/had cancer:

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous Bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, Multiple Myeloma or Metastatic Cancer □ Yes □ No

COMMUNITY HEALTH ALLIANCE

FAMILY HISTORY-Indicate which relative has had the following disease (parents and siblings are most important)

Are you adopted and have no known family history? ☐ Yes ☐ No

Disease	Mother	Father	Siblings	Disease	Mother	Father	Siblings	Disease	Mother	Father	Siblings
No significant history known				Cancer Ovarian/ Cervical				High Blood Pressure/ Hypertension			
Alcohol abuse/Drug abuse				Cancer Prostate				High Cholesterol			
Alzheimer's/Dementia				Cancer other type				Hypothyroidism/Thyroid Disease			
Autoimmune Disease				Depression/Suicide/ Anxiety				Kidney Disease			
Cancer Breast				Diabetes				Osteoporosis			
Cancer Colon				Heart Disease				Stroke/CVA			

OTHER HEALTH ISSUES

Tobacco Use:
☐ Yes ☐ No ☐ Never Quit date_____
Approximately how many packs/day?____ # of years:_____
☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew
☐ Electronic Cigarettes/ Vape ☐ Cigarettes

Alcohol Use:
Do you drink alcohol? ☐ Yes ☐ No # of drinks/week_____
Is your alcohol use a concern for you or others? ☐ Yes ☐ No

Safety: ☐ Decline to answer
Do you use a bike helmet? ☐ Yes ☐ No
Do you use seatbelts consistently? ☐ Yes ☐ No
Does your home have a working smoke detector? ☐ Yes ☐ No
If you have guns in your home, are they locked up? ☐ Yes ☐ No
Do you feel safe in your home? ☐ Yes ☐ No

Substance Use:
Do you use recreational drugs? ☐ Yes ☐ No
Have you ever used needles to inject drugs? ☐ Yes ☐ No

Sexual and Reproductive Health:

Are you currently using birth control?	☐ Yes ☐ No
Are you planning to have any/more children this year?	☐ Yes ☐ No
Would you like to discuss other birth control options?	☐ Yes ☐ No
Sexually active in past 3 months:	☐ Yes ☐ No # of partners_____ ☐ Declined
Who do you a have sex with	☐ Men ☐ Women ☐ Both ☐ Other ☐ Declined
Have you had a sexually transmitted infection?	☐ Yes ☐ No
Have you ever had sex for money or traded for sex?	☐ Yes ☐ No

Women's Health History:
Total number of pregnancies:____ Number of deliveries: _____
Age periods started:_____ Age periods ended: _____ ☐ N/A
Are you pregnant? ☐ yes ☐ no Due date: _____

Social Support:
Spouse/Partner's name: _____ Number of children _____
Who lives with you? Ages if under 18 years of age:

Have you completed an Advance Directive for Health Care Living Will or POLST (Physician Orders for Life Sustaining Therapy?)
☐ Yes ☐ No If yes, was copy provided? ☐ Yes ☐ No

Education Level:
Highest grade completed:

COMMUNITY HEALTH ALLIANCE

DENTAL HISTORY			
Are your teeth sensitive to the cold, hot, sweets or pressure?	☐ Yes ☐ No ☐ DK	Do you have any clicking, popping or discomfort in the jaw?	☐ Yes ☐ No ☐ DK
Are you experiencing dental pain or discomfort?	☐ Yes ☐ No ☐ DK	Do you brux (clench) or grind your teeth?	☐ Yes ☐ No ☐ DK
Do you have any oral piercings/jewelry?	☐ Yes ☐ No ☐ DK	Oral habits (chewing fingernails, clenching, etc.)	☐ Yes ☐ No ☐ DK
Is your mouth dry?	☐ Yes ☐ No ☐ DK	Do you have any sores or ulcers in your mouth?	☐ Yes ☐ No ☐ DK
Have you had any periodontal (gum) treatments?	☐ Yes ☐ No ☐ DK	Have you ever had orthodontic (braces) treatment?	☐ Yes ☐ No ☐ DK
Do you bleach your teeth?	☐ Yes ☐ No ☐ DK	Do you wear a mouth guard when playing contact sports?	☐ Yes ☐ No ☐ DK
Have you had any problems associated with previous dental treatment	☐ Yes ☐ No ☐ DK	Have you ever had a serious injury to your head or mouth?	☐ Yes ☐ No ☐ DK
How many times do you brush daily?		How many times do you floss daily?	
How do you feel about your smile?			
Do you drink bottled water or filtered water? ☐ Yes ☐ No ☐ DK If yes, how often? Circle one: Daily Weekly Occasionally			
Date of your last dental exam:_____ ☐ Unknown What was done at the time:_____ ☐ Unknown		Date of last X-rays:_____ ☐ Unknown	
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ Yes ☐ No ☐ DK Name of physician or dentist making recommendation: ☐ Unknown			

_____ _____

Signature Date