Siskiyou Community Health Center

DENTAL CLINIC

Establishing Care

What do I need to bring to my first appointment?

- Insurance cards.
- Picture ID, state issued and current.
- Payment for today's visit.
- A list of all medications you currently take both prescribed and over the counter, including supplements and vitamins.
- Completed new patient paperwork – downloaded from our website or received in the mail.
- Completed slide application and acceptable proof of income if you are applying for our Sliding Discount Program.
- X-rays taken within the last year. If a full mouth series or panoramic film was taken within the last five years, please bring that as well. If films are to be sent from another office please verify prior to your appointment we have received them to avoid delaying your appointment.

  State law requires that a dental office have copies of the requested information available within two weeks, originals are retained by the original provider.

Do I need to confirm my appointment?

As a courtesy, we will place a reminder call to you prior to your appointment. Please be aware that, if we are unable to reach you, we do request that you CALL US to confirm your appointment at least **24 hours** ahead of your appointed time. Without this confirmation, your appointment may be cancelled.

We ask that you please arrive 30 minutes early to your first appointment to allow time to complete registration. Late registration may require the appointment to be rescheduled.

SISKIYOU COMMUNITY HEALTH CENTER

Patient Registration

Welcome to Siskiyou Community Health Center. We are committed to providing quality, cost-effective health care for you and your family. Please feel free to speak with your provider if you have any questions about your care. If you have any questions about clinic policies or procedures, please speak with the clinic manager.

1 PATIENT DEMOGRAPHICS

Full Name _____ Nickname _____

SSN_____ Date of Birth_____ Birth Sex ☐Female ☐Male

Billing Address _____ City_____ State_____ Zip_____

Home Address _____ City_____ State_____ Zip_____

Home Phone _____ Day Phone _____ Cell Phone _____

Preferred Notification for Reminders ☐ Phone Call ☐ Text Message ☐ Opt Out (No Reminders)

Emergency Contact Name/Relationship _____ Phone_____

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

Primary Language ☐English ☐Spanish ☐Sign Language ☐Other_____Do you need an interpreter? ☐Yes ☐No

Name of Spouse/Significant Other**_____

SSN_____ Date of Birth_____ Phone _____

If you would like this person to be able to discuss your medical care and/or billing issues, please request an Authorization Form.

Primary Pharmacy_____ Secondary Pharmacy _____

2 INSURANCE INFORMATION - Please provide your insurance card(s)

Name of Primary Insurance_____ Policy #_____

Policyholder Name_____ Date of Birth_____

Name of Secondary Insurance_____ Policy #_____

Policyholder Name_____ Date of Birth_____

3 MINOR PATIENTS ONLY

Mother's Name_____Date of Birth_____ SSN_____

Address_____ Phone_____

Father's Name_____ Date of Birth_____ SSN_____

Address_____ Phone_____

4 PATIENT STATISTICS

As a Federally Qualified Health Center, we are able to offer services to all our patients, including the underserved, as a result of funding from Federal Grants. In order to receive grant dollars we are required to gather, on a yearly basis, statistics about the patients we serve. This information is confidential and will be used for statistics purposes only. We appreciate you taking the time to fully complete all questions in this section.

What is your living status? ☐Homeless ☐Not Homeless **Are you a Migrant Farm Worker?** ☐Yes ☐No

What is your Race? ☐White ☐American Indian/Alaska Native ☐Asian ☐Black/African American
(mark all that apply) ☐Native Hawaiian ☐Pacific Islander

What is your Ethnicity? ☐Not Hispanic/Latino ☐Hispanic/Latino **Are you a Veteran?** ☐Yes ☐No

Gender Identity? ☐Declined ☐Female ☐Male ☐Transgender F to M ☐Transgender M to F ☐Genderqueer ☐Other

Sexual Orientation? ☐Declined ☐Straight/Heterosexual ☐Lesbian/Gay ☐Bisexual ☐Something Else ☐Don't know

What is your Gross Annual Household Income? _____ **How many people are in your household?** _____

What is your employment status? ☐Employed ☐Homemaker ☐Retired ☐Student ☐Unemployed ☐ Disabled

If over age 18, what is the highest grade in school you completed? ☐Elementary ☐6th ☐7th ☐8th ☐9th ☐10th ☐11th ☐12th
☐GED ☐Attended College ☐ Associate's Degree ☐Bachelor's Degree ☐Master's Degree

5 BILLING AND COLLECTION POLICY

Payments of copays, deductibles and any other amount not covered by insurance is expected at the time of service. Any amount not received at your appointment will be billed on your monthly statement. All statements are due in full upon receipt unless prior financial arrangements have been made. Unpaid balances will be subject to our collection process, which may include assignment to an outside collection agency and possible discharge from the practice.

We will submit a claim to all contracted primary and secondary insurance companies with the exception of motor vehicle claims and out-of-state worker's compensation claims. It is your responsibility to supply us with a current copy of your insurance card(s) at each appointment. We do offer a sliding fee discount based on your income and family size. Please ask our front desk staff for an application.

The Billing Office is open Monday through Friday, 8:00 am to 5:00 pm. We accept all major debit/credit cards, checks, cash and Care Credit at our Dental facility. A $29 NSF fee will be applied for all returned checks.

I hereby authorize Siskiyou Community Health Center to provide services to the above named patient and to use and release medical or dental information as required for treatment, payment and health care or dental operations. I also assign Siskiyou Community Health Center payments to which I'm entitled for medical, surgical, behavioral health and dental expenses. I have read and understand the above policy regarding my financial responsibility for all services provided whether covered by insurance or not.

_____ _____
Patient or Patient Representative Signature **Date**

6 NO SHOW POLICY

An appointment that is not kept, not canceled 24 hours in advance, or is late is called a "No-Show". If you are unable to be at your appointment, it is your responsibility to call and reschedule or cancel the appointment.

New Patients–Failure to confirm or cancel your new patient appointment at least 24 hours prior to the appointment time will result in a "no-show" status. New patients that fail to provide appropriate cancellation notice for two (2) appointments will no longer be eligible to establish care with us for twelve (12) consectutive months.

Established Patients - If an established patient "No-Shows" four (4) times, they will be notified that they are no longer eligible to schedule future appointments and will be seen in the clinic on a *same day basis* only.

I have read and understand this "No-Show" policy.

_____ _____
Patient or Patient Representative Signature **Date**

Siskiyou Community Health Center

AUTHORIZATION TO EXCHANGE VERBAL HEALTH INFORMATION

PATIENT INFORMATION: *(Please print)*

Name: _____ Date of Birth: _____/_____/_____

EXCHANGE VERBAL INFORMATION TO:

Name: _____ Date of Birth: _____/_____/_____

Relationship: _____

INFORMATION TO BE DISCLOSED:

Initial all that apply.

_____ Medical Chart Notes	_____ Hospital Reports	_____ Dental Chart Notes
_____ Diagnostic Results	_____ Immunization	_____ Perio Chart
_____ Lab/Pathology	_____ Specialist Consults	_____ Radiographs
_____ Medication/Pharmacy	_____ Billing	_____ Appointment info.

This authorization may be revoked at any time by notifying a Siskiyou Community Health Center staff member. Such notice will be effective immediately upon receipt by Siskiyou Community Health Center records personnel. This consent will be ***valid up to one (1) year***.

Date consent begins: _____ Date consent expires: _____

Signature: _____ Date: _____

I recognize that the information discussed may contain information that is protected by federal and state laws (i.e. Drug/Alcohol Abuse, Mental Health, HIV/AIDS), and I specifically consent to the disclosure of such information.

Initial each one that applies:

_____ HIV/AIDS
_____ Mental Health
_____ Drug/Alcohol Abuse

Signature: _____ Date: _____

Siskiyou Community Health Center

ACKNOWLEDGMENT AND CONSENT

I understand that Siskiyou Community Health Center (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by This Practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice 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 and the information practices followed by the employees, staff and other office personnel of This Practice, 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 a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception areas.

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 This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____ Date: _____

(Patient Signature)

Print Name: _____ Date of Birth: _____

By: _____ Date: _____

(Patient Representative)

Description of Representative's Authority: _____

Effective Date: April 2008

Siskiyou Community Health Center

NOTICE: PATIENT PRIVACY

We are required by law to protect the privacy of your medical information and to provide you with written Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION

- We may use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

- We may be required or permitted by certain laws, regulations, or circumstances to use and disclose your medical information for certain purposes without your authorization. Under other circumstances we may need your written authorization (that you may later revoke) in order to use or disclose your medical information.

- As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

- We have available a detailed **NOTICE OF PRIVACY PRACTICES** which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the bottom right hand side of this page indicates the date of the most current NOTICE in effect.

- You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.

- If you have any questions, concerns or complaints about the NOTICE or your medical information, please contact the HIPAA Privacy Officer at 1-866-667-2870.

Siskiyou Community Health Center

PATIENT FINANICAL RESPONSIBILITY
DENTAL SERVICES

Thank you for choosing Siskiyou Community Health Center for your dental needs. We are committed to providing you with the highest quality dental care possible. We are providing this information regarding our financial policy to better assist you in determining your benefits and understanding your financial responsibility.

PRIVATE INSURANCE

We will bill your insurance for services provided; however, it is ***your responsibility to communicate with your insurance to determine if services are covered and what amount you will be responsible for***. For treatment services, we will provide you with a Proposed Treatment Plan indicating the recommended services and their estimated fees. You may use this document when contacting your insurance to assist with determining coverage.

Questions you may want to ask your insurance provider:

1. Does my policy cover this service and, if so, how much does my policy cover?
2. Is there a deductible that I am responsible for?
3. Is there a limit on the number of this type of service I can have in a year? What is the limit?
4. What dates are considered my policy year?
5. Is there a dollar limit on any of the services?

Once you have determined your estimated financial responsibility, you may contact our office to confirm or schedule your appointment(s).

We will contact your insurance prior to treatment to verify coverage and to determine if the service requires a prior authorization. If so, we will begin that process. If we receive a denial from your insurance for the prior authorization, we will contact you. For ***Crowns, Root Canals, Dentures, Bridges or Partials*** we will also request an estimate of patient responsibility within 30 days of the appointment. We will inform you of this estimated amount and will expect this to be paid by the time of service. For all other services, we will bill your insurance first before collecting from you.

For **ALL** services, any balance due after insurance processes the claim will be billed to you. ***We expect payment of this balance within 30 days of the statement date.***

(See other side for additional information)

SELF PAY/SLIDE

Services provided will be considered 100% patient responsibility, less the sliding fee discount for those who qualify.

For Preventive Services (*exams, cleanings, etc*) an estimated price range can be given to you upon request. If you do not qualify for the Sliding Discount Program, please ask our Registration Staff about our **Ounce of Prevention Program**. This program offers discounted services for preventive care.

For Treatment (*fillings, extractions, crowns, dentures, etc*), we will provide you with a Proposed Treatment Plan indicating the recommended services and their estimated fees. You may use this document to assist you in determining what treatment you can afford. Within 30 days of your treatment, we will create an estimate for you. This is the amount that will be due by the time of service.

**** IMPORTANT ****

All Proposed Treatment Plans and Estimates are ***estimates only***. The services and/or fees may be subject to change. We will do our best to make sure you have the most accurate financial information you need to make your treatment decisions; however, ***any changes to the estimated services/fees will be considered patient responsibility.***

Siskiyou Community Health Center

❒ **GRANTS PASS MEDICAL**
1701 NW Hawthorne Ave
Grants Pass, OR 97526
Phone: (541) 471-3455
Fax: (541) 471-1439

❒ **CAVE JUNCTION MEDICAL**
25647 Redwood Highway
Cave Junction, OR 97523
Phone: (541) 592-4111
Fax: (541) 592-3916

❒ **GRANTS PASS DENTAL**
1701 NW Hawthorne Ave
Grants Pass, OR 97526
Phone: (541) 479-6393
Fax: (541) 479-6489

PRESCRIPTION REFILL POLICY

We at Siskiyou Community Health Center are committed to providing excellent health care. We want to simplify the process to get you the medications you need in a timely manner.

We ask that you:

- **Bring all your medications to each visit, unless told differently by your Provider.**
- **Let the Medical Assistant and Provider know how many refills you will need to last until your next scheduled appointment.**
- **For new medications, ask for enough refills to last until your next appointment.**

Whenever you get your medication refilled at the pharmacy, check to see if you have any more refills left. If not, call us to schedule an appointment with your Provider. In most cases, if you need refills, we will ask you to come for an appointment.

If we are unable to get you an appointment before you will run out of your prescription, we will ask that you contact your pharmacy to fax us a refill request. Please allow three (3) business days for this process. If your request is on a Friday, it may not be ready until the following Wednesday.

You will still need to make an appointment to see your Provider for any more refills.

If you have a medication agreement with your provider for a narcotic or other controlled medications, follow the requirements of the agreement. If you do not know the requirements, ask for another copy of your agreement and discuss it with your Provider at your next appointment.

Thank you for your cooperation.

Siskiyou Community Health Center

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Phone: (541) 592-4111
Fax: (541) 592-3916

❒ **GRANTS PASS DENTAL**
1701 NW Hawthorne Ave
Grants Pass, OR 97526
Phone: (541) 479-6393
Fax: (541) 479-6489

❒ **MEDFORD HEALTHY FAMILIES**
1380 Biddle Road, St. D
Medford, OR 97504
Phone: (541)-500-8407

A new Federal Regulation has been adopted that is designed to protect patients from Identity Theft which is named the "Red Flag Rule." This rule states that medical offices are required to obtain a copy of a government-issued photo ID to protect patient from possible identity theft. Examples are: Driver's License, Military ID card, Passport, or State-issued ID card. Please bring your photo ID to your next appointment so we can place a copy in your chart. Thank you.

Siskiyou Community Health Center

HEALTH HISTORY

Patient Name _____ Chart # _____

Date of Birth _____

I. Circle Appropriate Answer (Leave blank if you do not understand the question)

Yes **No** Is your general health good?

Yes **No** Has there been a change in your health in the last year?

Yes **No** Are you under the care of a physician? If Yes, Name & Phone _____

If Yes, what is the condition being treated _____

Date of last medical exam _____

Yes **No** Have you been hospitalized or had a serious illness in the last three years?

If Yes, Please explain: _____

Yes **No** Have you had problems with prior dental treatment? _____ Date of last Dental exam _____

Yes **No** Are you in pain now? Describe _____

II. Do You Have or Have You Had:

Yes	**No**	Bleeding Problems, Bruising Easily	**Yes**	**No**	Thyroid, Adrenal Disease
Yes	**No**	Sinus Problems	**Yes**	**No**	Diabetes
Yes	**No**	Stroke, Hardening of Arteries	**Yes**	**No**	Seizures
Yes	**No**	Heart Disease	**Yes**	**No**	Dry Mouth
Yes	**No**	Heart Attack, Heart Defects	**Yes**	**No**	HIV or AIDS
Yes	**No**	Blood Transfusions	**Yes**	**No**	Tumors or Cancer
Yes	**No**	Heart Murmur	**Yes**	**No**	Radiation Treatments
Yes	**No**	Prosthetic Heart Valve	**Yes**	**No**	Chemotherapy (Pills and/or Injections)
Yes	**No**	Pacemaker	**Yes**	**No**	STD (Syphilis, Herpes or Gonorrhea)
Yes	**No**	Rheumatic Fever	**Yes**	**No**	Arthritis, Rheumatism
Yes	**No**	High Blood Pressure	**Yes**	**No**	Asthma, TB, Emphysema, other lung disease
Yes	**No**	Artificial Joint	**Yes**	**No**	Hepatitis, other Liver Disease
Yes	**No**	Stomach Problems, Ulcers	**Yes**	**No**	Kidney or Bladder Disease
Yes	**No**	Psychiatric Care	**Yes**	**No**	Osteoporosis

III. Are You Taking:

Yes **No** Recreational Drugs

Yes **No** Alcohol, Beer, or Wine

Yes **No** Tobacco (Pipes, Cigars, Cigarettes, Chew)

Yes **No** Drugs, Medications or over-the-counter medications (including Aspirin), Natural Remedies:

Please list: _____

IV. Women Only:

Yes **No** Birth Control Method: _____

Yes **No** Are you or could you be Pregnant or Nursing?

V. All Patients:

Yes **No** Do you have or have you had any other diseases or medical problems not listed on this form?

If Yes, Please explain: _____

_____

Yes **No** **Allergies to: Drugs, Foods, Latex:** _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medications.

Signature of Patient/Guardian _____ ***Date*** _____ ***Updated*** _____

Signature of Dentist _____ ***Date*** _____ ***Updated*** _____

Hygienist Initials _____

HEALTH HISTORY

This Section for Providers only:

Assessment Notes:

Recall Review: (Every 6 to 12 Months)

Patient _____ Date _____ Provider _____ Date _____

Patient _____ Date _____ Provider _____ Date _____

Patient _____ Date _____ Provider _____ Date _____

Siskiyou Community Health Center

What is the Sliding Discount Program (Slide Program)?

The slide program at Siskiyou Community Health Center is a federal program that allows us to offer discounts on our services to patients who may not have the ability to pay full fees.

Eligibility is based on your household size and income.

Who can apply for the Slide Program?

The slide program is *available to all of our patients*, even those who have insurance including Medicare, Oregon Health Plan and/or private insurance. Applying for our Slide Program has no impact on your current insurance coverage.

Who is included in the household?

The household includes yourself, spouse and any dependents under 19 years old that live with you. If you have a dependent that is a full time student under the age of 23 you can include them in your household if you claim them on your tax return. You will be asked to submit the most recent tax return as proof. Any other adults in the household, even if they are related, are not included.

What does the Slide Program cover?

Our slide discounts apply to all services at Siskiyou Community Health Center, including in-office procedures, dental care, pharmacy, and in-house labs.

If I already have insurance, why would I need the Slide Program?

While your insurance may cover many of the services you receive, the slide program may be able to assist on the balance due after insurance pays, such as copays, coinsurance or deductible amounts. It may also help reduce the cost of services your insurance may not cover such as labs, pharmacy or dental care.

How do I apply?

You will need to complete a one page application and submit proof of income for every adult listed in the household. If you do not have proof with you today, please talk to the Registration Staff regarding your options.

Once your application is approved it is valid until March 31st. A new application and proof of income will be required on or after April 1st each year to continue to be considered for the slide program.

What do I need to bring as proof of income?

- **Currently Employed?**
    - A copy of your most current month's worth of pay stubs. If you are paid monthly, you will need to bring 2 month's worth.

- **Self Employed?**
    - A copy of your most recent tax return including the signature page. If you do not file taxes, you will need to bring a financial summary for the current calendar year.

- **Unemployed?**
    - If you are receiving unemployment, you will need to submit documentation that indicates your weekly benefit amount.

- **Social Security Disability or Social Security Retirement Letter** – the most current award letter received. An SSA-1099 will not be accepted.

- **Worker's Compensation Award Letter**

- **Child or Alimony Support** – a copy of the court order showing the monthly amount received.

- **No Income?**
    - If an adult in the household does not work or is not receiving any income, a *Proof of No Income* form will need to be completed.

Note: Bank Statements will not be accepted unless requested by management.