THE PIC PLACE a MarillacHealth Clinic

Patient Registration/Update Form

Demographic Information

Date this Form Was Completed:

Legal First Name: | Legal Last Name: | Middle Initial:

Preferred Name (if different than above): | Previous Names (i.e., maiden, married):

Date of Birth: | Social Security Number (not required):

Sex at Birth: ☐ Male ☐ Female

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

Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other: _____

Race: ☐ White/Caucasian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Asian ☐ Pacific Islander/Hawaiian ☐ Prefer Not to Answer

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Prefer Not to Answer

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

Sexual Orientation: ☐ Straight/heterosexual ☐ Lesbian/gay ☐ Bisexual ☐ Other

Veteran Status: ☐ Veteran ☐ Spouse of Veteran ☐ Not Applicable

Household Status: ☐ Not Homeless ☐ At risk of homelessness ☐ Transitional housing ☐ Living with others ☐ Single-occupancy hotel ☐ Living in shelter ☐ Homeless unknown shelter ☐ Child at risk of homelessness ☐ Currently, not homeless, was in last 12 months ☐ Street, camp, or bridge ☐ Veteran at risk for homelessness

Employment Status: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Not employed ☐ Retired ☐ Disabled ☐ Child ☐ Full-time student ☐ Part-time student ☐ On active military duty ☐ Migrant Worker ☐ Seasonal Worker

Household Income:
** Note: This does not replace sliding fee Application process*

Family Size _____ Annual Household Income $_____

Contact Information

Mailing Address: City: State: Zip:

Cell: Can we text this number? Y / N | Home: | Work:

We will use this email address for the patient portal unless you opt out | Email Address: _____ | ☐ I choose to opt out

Creates a portal account for another person to access your health information | Email Address: _____ | Relationship to you _____

Emergency Contacts and Next of Kin

	Name	Relationship	Phone Number
Emergency Contact			
Next of Kin			
Guardian (if applicable)		Legal Guardian	
Home Support Agency / Caregiver (if applicable)		Agency/Caregiver	

THE PIC PLACE a MarillacHealth Clinic

Health Coverage Information			
Primary Insurance: _____	Subscriber's Name: _____	Date of Birth: _____	
Subscriber's ID: _____	Group #: _____		
Member ID #: _____	Relationship to Subscriber: _____		
Secondary Insurance: _____	Subscriber's Name: _____	Date of Birth: _____	
Subscriber's ID: _____	Group #: _____		
Member ID #: _____	Relationship to Subscriber: _____		

Current Health Care Providers (Care Team)				
	Name	Office	Date of Last Visit	I Don't Have Provider
Dentist				☐
Medical Doctor				☐
Counselor/Therapist				☐
Eye Doctor				☐
Specialist*(type):*				☐
Specialist*(type):*				☐
Specialist*(type):*				☐
	Name	**Phone Number**	**Address (if known)**	
Preferred Hospital				
Preferred Laboratory				
Preferred Pharmacy *(local)*				
Preferred Pharmacy *(mail in)*				
Medical Equip Provider				

By signing below, I attest that the information I have provided is accurate. I agree to update information as requested by the Clinic or when I have personal changes that change the information provided above.

_____ _____

Printed Patient Name Date

_____ _____

Patient/Legally Authorized Representative Signature If other than patient, Print name and Relationship

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Medical/Social Health History Questionnaire

Today's Date _____

Patient Last Name _____ DOB _____

Family History

Relationship	Diabetes	High Blood Pressure	High Cholesterol	Heart Attack	Cancer	Type of Cancer	Stroke	Blood Clots (legs, lungs,	Mental Health Issue	Substance Abuse	Other	Living Status
Mother												__ Alive __ Deceased
Father												__ Alive __ Deceased
Sister												__ Alive __ Deceased
Brother												__ Alive __ Deceased
Daughter												__ Alive __ Deceased
Son												__ Alive __ Deceased
Maternal Grandmother												__ Alive __ Deceased
Maternal Grandfather												__ Alive __ Deceased
Paternal Grandmother												__ Alive __ Deceased
Paternal Grandfather												__ Alive __ Deceased
Other important history, you want us to know about:												

Patient History

E-Cigarettes/Vaping (Circle one) Current Every-Day User Current Some-Day User Never Use

Former User Never assessed User-Current Status Unknown Unknown if Ever Used

E-Cigerette/Vaping Substance (Circle all that apply) Nicotine THC CBD Flavoring Other

Please list "Other" _____

E-Cigarettes/Vaping Devices (Circle all that apply) Disposable Pre-filled or Refillable Cartridge

Refillable Tank Other (Please list) _____

Tobacco Smoking (Circle one) Never Former Every Day Some Days Unknown

Smokeless (Circle one) Never Former Current Unknown

Passive Exposure (Second-hand smoke) (Circle One) Never Past Current

Would you like counselling on tobacco cessation? Yes No

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Medical/Social Health History Questionnaire

Alcohol

Do you drink Alcohol? Yes Not Currently Never

Drinks per Week? Glasses of Wine ___ Cans of Beer ___ Shots of Liquor ___ Drinks containing .05 oz of Alcohol ___

Did/do you ever drink excessively? Yes No Do you ever drive after drinking? Yes No

Drug Use (Circle one) Yes, Currently Not Currently Never **How many times per week?**_____

Types (Circle all that apply) Vaping Marijuana Opioids Heroin Methamphetamine

Amphetamines PCP ecstasy LSD Ketamine Mescaline Psilocybin Cocaine

Crack Nitrous Oxide Solvent Inhalants Barbiturates IV Other

Caffeine Intake

Do you drink/take caffeine? Yes No Number of cups/cans or amount taken per day? ____

Pharmacy Please list the name of your preferred pharmacy _____

Health Concerns/Diagnoses/Health Conditions Please list all current medical and mental health issues.

Issue	Onset

Surgeries Please list all previous surgeries and/or procedures.

Surgery	Reason	When/Where

Allergies Please list all allergies (medications, food, bee stings, etc.) and how they affect you.

Allergy	Reaction

2333 N. 6th St. Grand Junction, CO 81501
2139 N. 12th St., Ste. 2 Grand Junction, CO 81501
510 29 ½ Rd. Grand Junction, CO 81504
87 Merchant Drive, Montrose, CO 81401
Revised September 2023

Phone: 970-200-1600
Fax: 970-200-1611
MarillacHealth.org
Phone: 970-252-8896 Fax:970-240-3095

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Medical/Social Health History Questionnaire

Medications Please list all current medications that you are taking including over-the-counter medications.

Name	Dose	Frequency	Purpose	Who Prescribed

2333 N. 6th St. Grand Junction, CO 81501
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Accountable Health Communities Model Screening Tool

*Our goal is to connect you to the community resources you need to be healthy. This screener can help connect you to services in your community that may improve your health. Many of these services are low cost or free of charge. By answering these questions we may be able to provide you with connection to services or programs that may help you. You information will be kept confidential. The information that you provide will not impact your Medicare or Medicaid eligibility status. You should answer the questions in your own way. There are no right or wrong answers. Questions labeled with * are required.*

***First Name:_____ Middle Name: _____ *Last Name:_____**

*****Date of Birth:_____

Information

*Complete the following statement. I am answering this survey about …

□ Myself □ My child □ Other *(please describe your relationship to this person* _____

Health Coverage Type

*Health Coverage Type:

□ Medicaid □ Medicare □ Commercial □ Uninsured □Other

*How many times have you received care in an emergency room (ER) over the last 12 months?

If you are in the ER now, please count your current visit. Please do not count urgent care visits.

□ 0 times □ 1 time □ 2 or more times

Living Situation

What is your living situation today?

□ I have a steady place to live

□ I have a place to live today, but I am worried about losing it in the future

□ I do not have a steady place to live *(I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building)*

Think about the place you live. Do you have problems with any of the following?

□ Pests such as bugs, ants, or mice
□ Smoke detectors missing or not working
□ Oven or stove not working
□ Mold
□ Lead paint or pipes
□ Lack of heat
□ Water leaks
□ None of the above

Food

Within the past 12 months, you worried that your food would run out before you got money to buy more.

□ Often true □ Sometimes true □ Never true

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

□ Often true □ Sometimes true □ Never true

Transportation

In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting to things needed for daily living?

□ Yes □ No

Utilities

In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

□ Yes □ No □ Already shut off

Safety

Because violence and abuse happens to a lot of people and affects their health we are asking the following questions. (Please circle appropriate answer.)

How often does anyone, including family and friends, physically hurt you?

Never Rarely Sometimes Fairly often Frequently

How often does anyone, including family and friends, insult or talk down to you?

Never Rarely Sometimes Fairly often Frequently

How often does anyone, including family and friends, threaten you with harm?

Never Rarely Sometimes Fairly often Frequently

How often does anyone, including family and friends, scream or curse at you?

Never Rarely Sometimes Fairly often Frequently

Family and Community Support

How often do you feel lonely or isolated from those around you?

□Never □ Rarely □ Sometimes □ Often □ Always

Household Information

How many people do you currently live with? *Please count yourself, your spouse/partner, your children, and any other dependents. If you live alone, put 1.*

____number of people

What is your annual household income from all sources?

Please include your income as well as the income for everyone you counted above in your household.

- □ Less than $10,000
- □ $10,000 to less than $15,000
- □ $15,000 to less than $20,000
- □ $20,000 to less than $25,000
- □ $25,000 to less than $35,000
- □ $35,000 to less than $50,000
- □ $50,000 to less than $75,000
- □ $75,000 or more

What is the number of children under the age of 18 in your household? _____

You may be eligible for free, local care coordination services. Care Coordinators can help you navigate local resources such as housing assistance, accessing affordable/free food, transportation to medical appointments, utility payment support and other resources you may not realize are available.

I understand that this information may be shared with a care coordinator and that the care coordinator may contact me to help me access community resources for my identified needs.

Phone number care coordinator should use to contact you: _____.

If you do not want care coordination at this time, please check here ☐

FOR OFFICE USE ONLY

☐ Client has accepted navigation

☐ Client has declined navigation

Date Screened: _____

Date Entered in QHN: _____

Questions used with permission from the following authors (listed by number):

1 National Association of Community Health Centers and partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. http://www.nachc.org/research-and-data/prapare/

2 Nuruzzaman, N., Broadwin, M., Kourouma, K., & Olson, D. P. (2015). Making the Social Determinants of Health a Routine Part of Medical Care. Journal of Healthcare for the Poor and Underserved, 26(2), 321-327.

3 Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., Frank, D. A. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. Pediatrics, 126(1), 26-32. doi:10.1542/peds.2009-3146

4 National Association of Community Health Centers and Partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. http://www.nachc.org/research-and-data/prapare/

5 Cook, J. T., Frank, D. A., Casey, P. H., Rose-Jacobs, R., Black, M. M., Chilton, M., . . . Cutts, D. B. (2008). A Brief Indicator of Household Energy Security: Associations with Food Security, Child Health, and Child Development in US Infants and Toddlers. Pediatrics, 122(4), 867-875. doi:10.1542/peds.2008-0286

6 Sherin, K. M., Sinacore, J. M., Li, X. Q., Zitter, R. E., & Shakil, A. (1998). HITS: a Short Domestic Violence Screening Tool for Use in a Family Practice Setting. Family Medicine, 30(7), 508-512

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Behavioral Health Informed Consent to Treat

Patient Name: _____ ID:_____ DOB:_____

Degree's/Credentials:

Victoria Baumann earned her BA in Psychology from the University of Northern Colorado and her MA in Counseling from Adams State University. Victoria has been practicing as a Licensed Professional Counselor and a Certified Addictions Specialist since 2020.

> The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Colorado Department of Regulatory Agencies (DORA). DORA's Board of Licensed Professional Counselor Examiners, 1560 Broadway, Ste. 1370, Denver CO 80202. DORA specifies requirements for a Certified Addiction Specialist practicing counseling in the State of Colorado as having a Bachelor's degree along with 2,000 hours work experience, passing the jurisprudence and passing the NCAC II or MAC exams, along with training requirements. A Licensed Professional Counselor must have a Master's degree from an accredited university and obtain 2,000 hours of direct work experience post degree and pass the National Counselor Exam and register with the State of Colorado as a Licensed Professional Counselor.

Naomi McCrea, LCSW. Received her Master in Social Work-Clinical Track in 2014 from Virginia Commonwealth University in Richmond, VA. Received her BS in Sociology and BS in Human Development in 2012 from Virginia Tech in Blacksburg, VA. She is a Licensed Clinical Social Worker in the state of Colorado and has had her LCSW since 2018.

Consent:

1. I voluntarily agree to undergo mental health treatment and understand that I may end treatment at any time. I understand that my mental health provider may want to discuss this with me, but that I reserve the right to stop treatment at any time. Furthermore, I understand that my mental health provider may make diagnostic and treatment recommendations with which I do not agree (e.g. modality of treatment, duration of treatment, frequency of visits, etc.) and I may seek a second opinion from another counselor.

2. I am entitled to receive information about the methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure.

3. I understand that I am responsible for providing information for my evaluation and treatment as truthfully as possible and to the best of my ability.

4. I understand my mental health provider cannot guarantee *improved mental health* (e.g. less depressed, improved marital satisfaction, etc.) However, there will be clearly stated reasons, goals

and objective for continuing/discontinuing mental health treatment. This will be discussed with my mental health provider.

5. I understand that there may some risks in participating in mental health services. These may include, but are not limited to addressing painful emotional experiences and/or feelings; being challenged or confronted on a particular issue; reuniting with family members.

6. I understand that I have the right to an interpreter.

7. I understand that if I have a grievance with my mental health provider, I will first attempt to communicate this directly to him/her. In the event that the grievance is not satisfactorily resolved, I understand that I can ask the front desk for a Grievance form and assistance in filling it out or ask to speak to The PIC Place Executive Director at (970) 252-8896. I understand I also have the right to file a complaint by contacting the Mental Health Grievance Board at: Department of Regulatory Agencies, Mental Health Section, 1560 Broadway, Suite 1340, Denver, CO 80202, (303) 894-7766.

8. I understand payments for behavioral health visits will be billed through my insurance company, if applicable, and any co-pays are expected on the day of service.

9. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Executive Director or the board that regulates, registers, certifies or licenses the counselor.

10. Behavioral health visits follow the same policies related to no-shows and cancellations as medical visits.

11. The PIC Place has an integrated health care model and **summary** notes of your counseling visits are documented in an electronic medical record and shared with your medical and dental team at PIC.
    a. If you have any concerns, let me know if you would like to be referred to another counselor.
    b. We also share summary notes of your visits with our health information exchanges, Quality Health Network (QHN), CommonWell, and Carequality. In the event that you need care at the hospital, Emergency Department, or see other providers, they will be able to view what you are working on to better help you. Let me know if you would like to opt out of QHN or these other health information exchanges.
    c. Others taking care of you may request your medical record from The PIC Place with your signed medical record release. Your summary counseling notes will be included in your medical record unless you ask us on the release form not to include them.

12. I understand that the **detailed** information shared with my therapist is legally confidential, has special protections under the HIPAA Privacy rule, and in most cases, cannot be released without my

written consent. In certain legal circumstances, however, I understand this information can be shared with the proper authorities without my permission, and if feasible, I will be informed accordingly. Colorado law mandates the following exceptions to confidentiality:

- If you are deemed a danger to yourself or to others.
- If concerns of possible sexual, elderly or child abuse/neglect arise.
- If a court order/subpoena is issued to obtain records.
- If these records are required by a medical examiner or coroner.

13. I have been informed that I can see information about my counseling care or message my behavioral health provider securely through the patient portal. The patient portal should never be used for emergencies.
    - Should you wish another person to also access your patient portal, and are 18 or older, you may add a portal proxy which you can revoke at any time.
    - A parent's or legal guardian's proxy access to a child's portal will be terminated on the child's 12th birthday. A medical power of attorney may request access to a teenager's portal.

14. I understand I may request an electronic or paper copy of my medical record to share by signing a release form.

15. I understand that photographs, videos, and computer images may be taken of me for the purposes of security, identity protection, providing and documenting the treatment and care I receive. These images are not to be used for any other purpose other than security, identity protection, providing and documenting the care rendered. Telehealth videos and conversations are not saved or in the medical record.

Client consent: I have read this information, have had the opportunity to ask questions, and understand my rights as a client. By signing below, I acknowledge my agreement with the terms above and consent to evaluation and treatment. I understand I have the right to withdraw my consent at any time. I understand this consent to treat will expire in 12 months from the date of signature, unless otherwise specified. I also understand that I have the right to ask questions of my counselor about this information at any time.

_____ Date:_____

Signature of patient ages 12 years or older

Why Are You Receiving This Good Faith Estimate?

This **Good Faith Estimate** complies with the **Department of Health and Human Services (HHS) No Surprises Act**.

This is not a contract. It does not obligate you to accept the services listed. The purpose of the Good Faith Estimate you are receiving is to provide you with an approximate cost of services you will receive from our practice that will not be paid by health insurance.

Reasonably expected costs have been included in your estimate and are based on information known to our practice when it was prepared.

Any unknown or unexpected costs that may arise during treatment due to complications or unusual circumstances have NOT been included in this estimate. If they occur, and you are billed at least $400 above the amount indicated on this Good Faith Estimate (per provider), federal law allows you to dispute (appeal) your invoice for services in the following two ways:

1. **Contact Us:** You may direct any questions or concerns you have regarding this estimate or any invoice to our practice. Please find our contact information below. Federal law permits you to ask that we update your invoice to match the Good Faith Estimate you received. You can also ask to negotiate the invoice amount or inquire about the availability of financial assistance.

2. **File a Formal Dispute Resolution:** You may also file a formal dispute online with the **Centers for Medicare & Medicaid Services (CMS)** (www.cms.gov/nosurprises) or by calling 1-800-985-3059.

   If you choose to file a formal dispute resolution, you must **start the process within 120 calendar days** of the date on the original invoice you receive. There is a **$25 fee** to use the dispute process. If your dispute **is approved**, you may be eligible to pay the lower amount on the Good Faith Estimate you received. If it is **not approved**, you will be obligated to pay the higher invoiced amount.

   IMPORTANT: It is recommended that you keep a paper or electronic version of this Good Faith Estimate in a safe place. You may need it should you choose to file a formal dispute.

Thank you for trusting us with your medical care. Please find your Good Faith Estimate on the back of this page. If you have any questions about this Good Faith Estimate or future invoices, **please do not hesitate to contact our Billing Department: 970-200-1600 (Menu options 1, then 3).**

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Zero Tolerance Policy

The MarillacHealth has a zero tolerance policy. Patients may ultimately be dismissed from the practice and removed from a provider's panel for failing to abide by this policy. If dismissed, patients will be informed in writing and will not be allowed back into any of the Marillac facilities or departments.

Below are some examples of behavior that will not be tolerated:

- Use of force or attempt to assault patients, visitors or health center staff
- Use of force or destruction of physical property in the premises of the health center, including parking and common areas
- Use of inappropriate touching, spitting, raising fists or feet or verbally threatening language
- Sexually inappropriate gestures or language against patients, visitors or staff
- Racial remarks or shouting at any person
- Intimidating behavior such as banging on counters, doors, etc.
- Persistent non-compliance with care (medication management) or care planning
- Persistent abuse or overutilization of services
- Persistent no-shows
- Severe breakdown in the provider-patient relationship
- Smoking in bathrooms/facilities/premises

Aggressive/abusive behavior is not tolerated and each event is discussed and recorded. Aggressive/abusive patients may be escorted or removed from the facility by security or the police. If removed by the police, patients may be charged with trespassing or charged with criminal charges.

_____	_____
Signature of Patient or Legal Guardian	Today's Date
_____	_____
PRINTED Name of Patient	Patient Date of Birth
_____	_____
PRINTED Name of Legal Guardian	Legal Guardian Relationship to Patient

2333 N 6th St. Grand Junction, CO 81501
510 29 ½ Rd, Grand Junction, CO 81504
www.MarillacHealth.org

Medical: 970-200-1600
Dental: 970-200-1600
Fax: 970-200-1612

Authorization for Treatment

PERMISSION FOR TREATMENT:

I understand that all patients of MarillacHealth may be seen by staff or volunteer physicians, physician's assistants, or nurse practitioners who are licensed in the State of Colorado and are supervised by the Clinic's Medical Director and/or Dental Director. I hereby give permission for evaluation and treatment, for myself or for the minor child named, by these providers. I understand that the Clinic functions as a teaching facility for medical/dental students of all disciplines, and those patients may be seen by these students. I understand that all students are under the direct supervision of the medical/dental staff of the Clinic. I understand that I have the right to request that I not be treated by a student. I understand that this care may include routine clinic procedures, diagnostic testing, intravenous therapy, injections, minor surgery, and no guarantees have been made to me about the services, treatment, or the outcome of this care. I understand that my prescription history may be obtained from any pharmacy I may have used.

USE AND DISCLOSURE OF INFORMATION FOR TREATMENT AND HEALTHCARE OPERATIONS:

I understand that federal regulations permit the Clinic to obtain, use, and disclose my protected health information for treatment, payment and health care operations and as otherwise allowed by law, as explained in the Clinic's Notice of Privacy Practices. I also understand that some or all of my medical records (or copies of my medical records) may be disclosed or provided to other health care providers (such as physicians, nurses, psychologists, or their staff) involved in my current or future treatment. This type of disclosure may be by written correspondence, in person, by fax, by phone, or other means. I understand that my permission is not needed for those uses or disclosures. The Clinic may also release my information in order to process payment claims. While this office will make reasonable efforts, I understand that the confidentiality of my medical records cannot be ensured once they leave this office. I understand that my picture may be taken and or my photo ID may be scanned and used for identity verification. I understand my records may contain identifying information including photographs, examination, treatment, diagnosis and prognosis and amounts charged and paid, as well as sensitive information concerning substance abuse, psychiatric history and treatment, HIV status, any diagnosis / treatment for AIDS or AIDS-related disease, sexual orientation, and/or sexual activities or disease. I understand that this information may be released or disclosed as necessary in accordance with the Clinic's Notice of Privacy Practices unless otherwise protected or provided for by state or federal law. I understand that I may request restrictions on how any of my health information and/or my medical records is to be used, disclosed or shared. (I understand that the Clinic and St. Mary's Hospital participate in a Continuum of Care Agreement whereby billing and clinic information is shared without specific consent from me.) I understand that the Clinic utilizes a collaborative care model for treatment and that mental health records are part of the medical record.

PATIENT FINANCIAL RESPONSIBILITY:

I agree to provide all financial information requested by the Clinic in order to qualify for services. I attest that all of this information is accurate to the best of my knowledge. I understand that if I provide false financial information or fail to update changes in income or insurance status, that I may no longer be eligible for Clinic services. I understand that the Clinic expects payment of incurred expenses at the time of the visit. If I am not able to pay the reduced fee at this time, I will meet with the Clinic's appropriate personnel to make payment arrangements. I understand that there may be additional fees for Immunizations, lab work, procedures, medications or other items. I understand that I may be referred

Authorization for Treatment

to a specialist physician for consultation or treatment. I understand that I, as the patient, am financially responsible for payment of all charges for services provided by these specialists. I understand that the Clinic is not financially responsible and will not pay for any services outside the Clinic. I understand that the Clinic provides only routine, outpatient care during regular posted office hours, and that should emergency or life-threatening events occur I will access care at an emergency facility at my own expense. I understand that if I am in a life-threatening condition while at the Clinic, emergency transportation will be called to transport me to an emergency room. I understand that I am financially responsible for the cost of such emergency care and transportation. I realize that failure to keep my appointments, to cancel my appointments or arrive late for an appointment may jeopardize my eligibility for continued care at the Clinic.

ASSIGNMENT OF BENEFITS / MEDICARE AND MEDICAID:

I certify that the information given by me in applying under Title XVIII of the Social Security Act is correct.

I authorize the Clinic to release to the Social Security Administration or its intermediaries or carriers or insurance companies any information needed for this or a related Medicare/Medicaid claim or a private insurance claim. I assign the benefits payable for the physician services to the physician or organization furnishing the services so that the Clinic can directly be paid or authorize such physician or organization to submit a claim to Medicare/Medicaid for payment to me.

I understand this entire consent, financial responsibility and assignment of benefits form will be valid now and in the future until revoked in writing by me and the revocation given to the clinic.

Signature of Patient or Legal Guardian	Today's Date
PRINTED Name of Patient or Legal Guardian	Relationship to Patient
Patient Name	Patient DOB

a MarillacHealth Clinic

Verbal Communication Consent

Patient Last Name _____ **First** _____ **Middle** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Social Security #_____ **Date of Birth** _____ **Phone number** _____

Verbal Disclosure

I authorize The PIC Place/MarillacHealth to leave messages regarding medical information pertaining to my care by the following methods and will assume responsibility to notify The PIC Place/MarillacHealth when the information changes. (Check all that apply.)

Home Phone _____ Work Phone _____ Cell Phone _____ Voicemail/Answering Machines _____

Disclosure to other persons

I authorize The PIC Place/MarillacHealth to speak with the following individual(s) regarding my current care and treatment:

Name _____Relation _____Phone #_____

Name _____Relation _____Phone #_____

Name_____Relation _____Phone #_____

All health information, including billing, may be communicated to the above listed individuals except for the following:

Diagnosis or reference to behavioral health services/psychiatric care; sickle cell anemia; genetic testing; acquired immune deficiency syndrome (AIDS); human immunodeficiency virus (HIV); sexually transmitted infection (STI); or drug and/or alcohol abuse.

This authorization does not expire unless I revoke or change the authorization.

I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it.

Information disclosed pursuant to the authorization may be subject to redisclosure by the recipient and is no longer protected by the HIPAA Privacy Rule.

My signature is required to validate this authorization. If I do not sign this authorization, The PIC Place/MarillacHealth will still provide treatment and seek payment for services provided. According to State Statures, this care site may change for copies of medical records.

Patient or Parent/Legal Guardian Signature_____ Date _____

Notice of Privacy Practices

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

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.

If you have any questions, contact Privacy Officer at 970-200-1600; or by mail at 2333 N. 6th Street, Grand Junction, CO 81501. To learn more about MarillacHealth, please visit our website at www.MarillacHealth.org

Medical information about you and your health is private. We strive to protect your health records when you are being seen in the clinics. We will use your records to care for you, bill for care, and to comply with the law.

This Privacy Notice applies to all MarillacHealth clinic services sites. This Notice tells you about the ways MarillacHealth may use or give out information from your private health records. It also explains your rights and responsibilities.

Note: The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all physicians and health care facilities to provide patients with a notice describing how an individual's medical information may be used and disclosed, and how a patient may obtain access to their personal health information.

Who Follows The Terms of This Notice:

- Any health care provider who treats you at any of our locations
- All employees, volunteers, and staff at the hospital and clinics
- Healthcare students in training programs
- Any business associate who performs work for us that requires them to see your medical or dental information to do their jobs

Acknowledgement of Receipt:

I understand that, as allowed and required by law, MarillacHealth staff will use and give out my health records, without my consent or authorization, for:

- Treatment: Care providers will use my health history, symptoms, exams, test results, diagnosis, treatment and plan of care to take care of me.
- Payment: MarillacHealth will use my health records to bill me, my insurance or other aid programs for my care if this applies to the clinic where I receive my care.
- Healthcare Operations: MarillacHealth will use my health records to run the clinics and to make sure patients receive quality care.

Please note that a copy of HIPAA is available upon request for the patient or parent/guardian of a minor receiving medical, dental or mental health counseling services at MarillacHealth. Prior to receiving services, you must sign below, certifying that you understand a copy of our HIPAA policies is available.

Signature of Patient or Legal Guardian	Today's Date
PRINTED Name of Patient or Legal Guardian	Relationship to Patient
Patient Name	Patient DOB

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: January 1, 2023

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We provide health care to our patients together with physicians and other health care professionals. This Notice of Privacy Practices ("Notice") describes how we will use and disclose protected health information.

I. Our Commitment to Safeguard Your Protected Health Information.

Each time you visit our facility, a record of your visit is made. Information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is called protected health information ("PHI"). Your medical record is a means of communication among the many health professionals who care for you. PHI may include documentation of your symptoms, examination, test results, diagnoses and treatment. It also includes documents related to billing and payment for care provided.

We are committed to protecting the privacy of your protected health information. We are required by law to:

- Maintain the privacy of your protected health information;
- Provide you with this Notice about our privacy practices that explains how, when, and why we use and disclose your protected health information;
- Abide by the terms of the current Notice;
- Make a good faith effort to obtain your written acknowledgment that you have received this Notice; and
- Notify you following a breach of your unsecured protected health information.

II. How We May Use and Disclose Your Protected Health Information

This Notice informs you about the ways in which we may use and disclose your protected health information. The following categories describe different ways that we use and disclose protected health information. For each category of uses or disclosures, we explain what we mean and give some examples to help you better understand the meaning. If a use or disclosure is not included in one of these categories, we will seek your permission first.

<u>Uses and Disclosures Without Your Permission</u>

The following categories describe different ways that we are permitted to use and disclose your protected health information without your permission (which is called an "authorization" under HIPAA).

For Treatment

We may use and disclose your protected health information to provide you with medical and dental treatment and services. We may disclose protected health information about you to doctors, nurses, technicians, medical students, and other healthcare personnel who provide you with healthcare services or are involved in taking care of you. This may include health care professionals at other facilities, such as your doctor's office, other hospitals, nursing homes or home health agencies. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process.

For Payment

We may use and disclose your protected health information to obtain payment for your health care services provided by us. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Health Care Operations

We may use and disclose your protected health information for operations necessary for our facility to function and make sure our patients receive quality care. For example, we may use your protected health information in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. This information may also be used in an effort to continually improve the quality and effectiveness of the health care and services we provide. We may disclose your protected health information to another health care provider or a health plan that you have a relationship with, for their operations' activities.

Business Associates

We may disclose your protected health information to other companies that help us. These business associates may include billing companies, claims processing companies, collection agencies, accountants, attorneys, consultants, and others that assist us with payment activities or health care operations. We contractually require our business associates to safeguard the privacy and security of your PHI.

Individuals Involved in Your Care or Payment for Your Care

We may disclose protected health information about you to a family member, personal representative, or other person involved in your care or responsible for payment of your health care services. We may also discuss your condition with your family or friends and tell them that you are in the hospital. If you do not want us to share information with your family or others involved in your care, please contact the person listed in Section V of this Notice.

Public Health Authorities

We may disclose your health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made to a public health authority for the purpose of preventing or controlling disease. We may also disclose your protected health information to a person or company subject to the jurisdiction of the FDA to report adverse events, product defects or problems or biologic product deviations; to track FDA-regulated products; to enable product recalls; to make repairs or replacements; or for other purposes related to the quality, safety or effectiveness of a product or activity regulated by the FDA.

Public Safety

We may disclose protected health information for public safety purposes in limited circumstances. We may disclose protected health information to law enforcement officials in response to a search warrant or a grand jury subpoena. We also may disclose protected health information to assist law enforcement officials in identifying or locating a person, to prosecute a crime of violence, to report deaths that may have resulted from criminal conduct, and to report criminal

conduct at the facility. We also may disclose your protected health information to law enforcement officials and others to prevent a serious and imminent threat to health or safety.

Judicial and Administrative Proceedings

We may disclose protected health information if we are ordered to do so by a court, for an administrative hearing, or if we receive a subpoena or a search warrant. You will receive advance notice about this disclosure in most situations so that you will have a chance to object to sharing your protected health information.

Fundraising Activities

We may use your protected health information in an effort to raise funds for our facility with your consent. The money raised through these activities is used to expand and support the health care services and educational programs we provide to the community. If you do not wish to receive our fundraising communications, you may notify our Donor Relations Department and we will honor your wish. Future treatment or payment will not be a condition upon your decision regarding receipt of fundraising communications.

Disaster Relief Efforts

As part of a disaster relief effort, we may disclose your protected health information to an agency assisting in the relief effort so that your family can be notified about your condition, status and location. You may have the opportunity to object, unless it would impede our ability to respond to emergency circumstances.

Coroners, Medical Examiners, and Funeral Directors

We may disclose health information consistent with applicable law to coroners, medical examiners, and funeral directors to assist them in carrying out their duties.

Research

Under certain limited circumstances, we may use and disclose your protected health information for research purposes. For example, a research project may involve comparing the health and recovery of all patients who receive one medication to those who receive another for the same condition. All research projects are subject to a special approval process. Before we use or disclose protected health information for research, the project will have been approved through this research approval process.

Reports Required by Law

We will disclose your protected health information when required to do so by federal, state, or local law. For example, we make disclosures when a law requires that we report information to government agencies and/or law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot and other wounds; to report reactions to medications or problems with products; or to notify people of product recalls.

Public Health Activities

We may disclose your protected health information for public health activities. For example, we report information about births, deaths, and various diseases to government officials in charge of collecting that information.

Health Oversight Activities

We may disclose protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.

Organ and Tissue Donation

If you are an organ donor, we may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.

Workers' Compensation

We may disclose your protected health information to the extent necessary to comply with laws relating to workers' compensation or similar programs providing benefits for work-related injuries or illness.

Military, Veterans, National Security, and Other Government Purposes

If you are a member of the armed forces, we may release your health information to military command authorities or to the Department of Veterans Affairs if they require us to do so. We may also disclose protected health information for certain national security purposes and to the Secret Service to protect the president.

Correctional Institutions

If you are or become an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official. This disclosure may be necessary for the institution (i) to provide you with health care; (ii) to protect your health and safety or the health and safety of others; or (iii) for the safety and security of the correctional institution.

Participation in Health Information Networks

We participate in the Colorado Regional Health Information Organization (CORHIO) and/or Quality Health Network (QHN), CommonWell, and Carequality Health Information Exchanges, which are secure computer networks which provide safe and efficient ways to share protected health information with other health care providers. For example, if you require emergency medical care while you are traveling, providers at other health care facilities in Colorado could have access to your protected health information to assist them in caring for you. By participating in these networks and other electronic information exchanges, we intend to provide timely information to health care providers involved in your care. If you do not want your information to be shared through these networks, you may "opt out" by contacting the person listed in Section V below. This is an "all-or-nothing" choice, because health information exchanges cannot block access to some types of protected health information while at the same time permit access to other protected health information. Opting-out of CORHIO and/or QHN may limit your health care providers' ability to provide the most effective care for you.

<u>Uses and Disclosures Requiring Your Permission</u>

Other uses and disclosures of protected health information not covered by this Notice will be made only with your written permission. If you provide us permission to use or disclose protected health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected health information about you for the reasons covered by your written authorization, but we cannot take back

any disclosures we have already made based on the permission you gave us before. If you want to revoke your permission, please contact the person listed in Section V of this Notice.

Marketing Activities

We will not use or disclose your PHI to sell you products or services of a third party unless you provide permission. We may suggest products or services to you during our face-to-face communications.

Sale of PHI

We will not sell your PHI (Personal Health Information) to third parties without your permission.

Protected Health Information That Has Special Protection

Psychotherapy Notes

Psychotherapy notes are the personal notes of psychotherapists. We must obtain your permission to use or disclose psychotherapy notes, except under limited circumstances.

Alcohol and Drug Abuse Patient Records

Use and disclosure of any protected health information about you relative to alcohol or drug abuse treatment programs, is protected by federal law. Generally, we will not disclose any information identifying you as a recipient of alcohol or drug abuse treatment unless: (i) you have consented in writing; (ii) we receive a court order requiring the disclosure; (iii) the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; or (iv) disclosure is required to report child abuse or neglect.

HIV/AIDS Information

Use and disclosure of any protected health information about you relative to HIV testing, HIV status, or AIDS, is protected by federal and state law. Generally, we will need your permission to disclose this information; however, state law may allow for disclosure of information for public health purposes.

Minors

As a general rule, we disclose PHI about minors to their parents or legal guardians. However, in instances where state law allows minors to consent to their own treatment without parental consent (such as HIV testing), we will not disclose that information to a minor's parents without the minor's permission unless otherwise specifically allowed under state law.

III. Your Rights Regarding Your Protected Health Information

The following section describes your rights with respect to your protected health information and a brief description of how you may exercise these rights.

The Right to Inspect and Obtain a Copy of Your Protected Health Information

You have the right to see and receive a paper or electronic copy of protected health information maintained by us that may be used to make decisions about your care. (The law requires us to keep the original record.) Usually, this includes

your medical and/or dental and billing records. To inspect and/or receive a copy of your protected health information, you must submit your request in writing to our Health Information Management/Medical Records Department, 2333 North 6th Street, Grand Junction, CO 81501. If you request a copy of the information, we may charge you a reasonable fee based on our costs.

The Right to Amend

If you believe that protected health information we have about you is incorrect or incomplete, you have the right to request that we correct the existing information or add missing information. To request an amendment, you must make the request in writing along with your reason for the request to the person listed in Section V below.

The Right to a List of Disclosures

You have the right to request a list of certain disclosures of your protected health information. To request this list or accounting of disclosures, you must submit a request in writing indicating a time period, which can be no longer than six years, to the person listed in Section V below. The first list you request within a 12-month period will be free. For additional lists during the same year, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

The Right to Request Restrictions on How We Use and Disclose Your Protected health information

You may ask us not to use or disclose your protected health information for a particular reason related to treatment, payment or health care operations. We will consider your request, but we are not legally obligated to agree to a requested restriction except in the following situation: if you have paid for services out-of-pocket in full, you may request that we not disclose information related solely to those services to your health plan. We are required to abide by such a request, except where we are required by law to make the disclosure. To request restrictions on the use or disclosure of your PHI, you may do so at the time you register for services or by contacting the person listed in Section V below.

The Right to Request Confidential Communications

You have the right to ask that protected health information about you be communicated to you in an alternate confidential manner, such as asking that appointment reminders not be left on an answering machine, that mail be sent to an alternate address, or that notices or reminders be sent by e-mail instead of regular mail. We will agree to all reasonable requests so long as we can easily provide it in the format you request. To request protected health information be sent to an alternative address or by other means, please contact the person listed in Section V below in writing, or in a clinic setting, please contact the practice manager.

The Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Paper copies are available at our registration locations and our HIM Department. You may also obtain a copy of this Notice on our website at MarillacHealth.org.

IV. Complaints

If you believe that we may have violated your rights with respect to your protected health information, you may file a written complaint with the person listed in Section V below. You also may initiate a complaint to the Office for Civil

Rights, U.S. Department of Health and Human Services. More information about this complaint process is available at https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html. You will not be penalized for filing a complaint about our privacy practices. You will not be required to waive this right as a condition of treatment.

V. Person to Contact for Information About This Notice or to Complain About Our Privacy Practices

If you have any questions about this Notice or wish to make a complaint about our privacy practices, please contact our Privacy Officer at 970-200-1600. Formal complaints must be in writing. Complaint forms are available at all registration areas or from the HIM Department. Complaints should be sent to the Privacy Officer at 2333 North 6th Street, Grand Junction, CO 81501 or by fax to 970-200-1611.

VI. Changes

We reserve the right to change the terms of this Notice and our privacy policies at any time. We reserve the right to make the revised Notice effective for protected health information we already have about you as well as any information we receive in the future. Before we make an important change to our policies, we will promptly change this Notice and post a new Notice in our registration areas. The Notice will contain the effective date. You can also request a copy of this Notice from the contact person listed in Section V above at any time or can view a current copy of the Notice on our website at www.marillachealth.org.

VII. OCHIN Collaborative

MarillacHealth is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of MarillacHealth, OCHIN supplies information technology and related services to MarillacHealth and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your personal health information may be shared by MarillacHealth with other OCHIN participants or a health information exchange only when necessary for medical treatment or for the health care operations purposes of the organized health care arrangement. Health care operation can include, among other things, geocoding your residence location to improve the clinical benefits you receive.
The personal health information may include past, present and future medical information as well as information outlined in the Privacy Rules. The information, to the extent disclosed, will be disclosed consistent with the Privacy Rules or any other applicable law as amended from time to time. You have the right to change your mind and withdraw this consent, however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided a list of entities to which your information has been disclosed.

VIII. Acknowledgment

You will be asked to sign an acknowledgement of your receipt of this Notice of Privacy Practices. We are required by law to make a good faith effort to provide you with our Notice of Privacy Practices and obtain an acknowledgement from you that you received it. Your care and treatment at our facility does not depend on signing the acknowledgment.