As a Federally Qualified Health Center, River Valley Primary Care Services is required to collect demographic information regarding the patients we serve. The information you provide is confidential.

Section 1: Patient Information

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

Social Security Number: _____ **Sex**: ☐ Male ☐ Female **Date of Birth**: _____

Mailing Address: _____ **City:** _____

State: _____ **Zip Code**: _____ **Primary Phone:** ☐ Home ☐ Cell ☐ Work _____

Preferred Communication: ☐ No Preference ☐ Phone ☐Mail ☐My Chart (If My Chart, please provide an email)

Email Address:_____ **Marital Status**: ☐ Single ☐ Married ☐ Other: _____

Ethnic Group (Please check one): ☐ Another Hispanic Latino/a or Spanish origin ☐ Cuban ☐ Mexican, Mexican American, Chicano/a ☐ Non-Hispanic or Latino/a ☐ Patient Refused ☐ Puerto Rican ☐ Unknown

Race: (Please check all that apply) ☐Alaska Native ☐ American Indian ☐ Asian Indian ☐ Black/African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Patient Refused ☐ Samoan ☐ Unknown ☐ Vietnamese ☐ White

RVPCS is a federally funded organization and therefore is required to ask our patients their sexual orientation as well as their gender identity in order to identify and reduce health disparities as well as promote culturally competent care. If you do not wish to disclose this information, please mark "Patient Refused"

Sexual Orientation: ☐ Straight/Heterosexual ☐ Bisexual ☐ Something else ☐ Don't Know ☐ Choose not to disclose ☐ Gay ☐ Lesbian ☐ Pansexual ☐ Queer ☐ Omnisexual ☐ Asexual

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female (Male-to-Female) ☐ Transgender Male (Female-to-Male) ☐ Other ☐ Choose not to disclose ☐ Non-Binary (Identifying as any other gender than female or male)

Pronouns*: ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Other _____
A pronoun is a word that substitutes for a noun, in this case, a word for your name. Please check one or more options of the pronouns you want people to use to refer to you.

Employer: _____ **Address:**_____ **Phone:**_____

Employment Status: ☐ Full Time ☐ Active Military Duty ☐ Part-Time ☐ Retired ☐ Seasonal ☐ Self Employed ☐ Student Full Time ☐ Student Part Time ☐ Unemployed due to Disability ☐ Not Employed

Homeless Status: ☐ Not Homeless ☐ Homeless shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐ Other _____

Worker Status: ☐ Migrant ☐ Not Migrant ☐ Seasonal **Veteran:** ☐ Yes ☐ No **Preferred Language:** _____

Special Needs? ☐ None ☐ Glasses ☐ Hearing Aids ☐ Service Animal **Needs Interpreter?** ☐ Y ☐ N

Preferred Pharmacy Name: _____ **City**: _____

Section 2: Guarantor (Financially Responsible Party) Information

Guarantor is: ☐ Patient (no need to complete the rest of this section) ☐ Person ☐ Company

Patient's relationship to Guarantor: ☐ Child ☐ Parent ☐ Spouse ☐ Employer ☐ Other: _____

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

Social Security Number: _____ **Sex**: ☐ Male ☐ Female **Date of Birth**: _____

Mailing Address: _____ **City:** _____

State: _____ **Zip Code**: _____ **Primary Phone:** ☐ Home ☐ Cell ☐ Work _____

Section 3: Household and Income Information

RVPCS is a federally funded organization and therefore is required to ask our patients about their family income for reporting.

If you are in need of financial assistance, please ask for our Sliding Fee Application. **Please indicate your family annual income (required information for federal reporting)**

How many persons are in the household? _____

____$0-$5,000 ____$5,000-$10,000 ____$10,000-$20,000 ____$20,000-$30,000 ____$30,000-$40,000

____$40,000-$50,000 ____$50,000-$60,000 ____$60,000-$70,000 ____$70,000-$80,000 ____$80,000-$90,000

____$90,000+ ____ Do not wish to Disclose/Unknown

Section 4: Insurance Information

Please provide your Insurance card(s)

Primary Insurance and policy number: _____

Secondary Insurance and policy number: _____

RVPCS Consent to Treat English

1. I _____ (patient or guardian name) give **River Valley Primary Care Services** permission to give medical, dental, and/or behavioral health treatment to the patient or myself named below.

2. I authorize **River Valley Primary Care Services** to file for insurance benefits to pay for the care I receive.

   I understand:
   - **River Valley Primary Care Services** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance*.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

_____ _____

Print Patient Name Date of Birth

_____

Print name (Parent or Guardian Name) (for children under 18)

_____ _____

Signature Date

* ☐ Please check if the patient is incarcerated. Must sign above for consent to treat.

RVPCS HIPAA Compliance Patient Consent Form

Patient Name: _____ Date of Birth_____

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You confirm your understanding with your signature below that you have reviewed RVPCS's Notice of Privacy Practices before signing this consent.

The terms of the Notice of Privacy Practices may be subject to change. If changes are made, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. RVPCS is not required to agree with the requested restrictions. However, if RVPCS does agree with the requested restrictions, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potential anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such revocation will not be retroactive.

By signing this form, you understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- You have the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon the execution of this consent.

May we call, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with family, friends, or caretakers? YES NO

If we are able to discuss your medical condition with anyone, please provide their information below:

Name: _____Relationship_____Phone_____

Name: _____Relationship_____Phone_____

Name: _____Relationship_____Phone_____

Name: _____Relationship_____Phone_____

Name: _____Relationship_____Phone_____

This consent was signed by: (PLEASE PRINT NAME) _____

Signature: _____ Date: _____

RVPCS NOTICE OF PRIVACY PRACTICES – Please keep this form for your records

River Valley Primary Care Services, Inc. is committed to maintaining the confidentiality (privacy) of health care information we create in providing services to you and, in partnership with you, insuring of that information.

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this notice describes how your health information may be used and disclosed by River Valley Primary Care Services, Inc. This notice also outlines how you can get access to your protected health information (PHI).

The terms of this privacy notice apply to all records created and retained in River Valley Primary Care Services, Inc. clinics for conducting our business as it relates to treatment and services provided to you. A copy of our notices of privacy practices are posted in the office.

River Valley Primary Care Services, Inc. reserves the right to alter our practices and make provisions, as needed, effective for all protected health information (PHI) we maintain as legal documents describing and documenting care.

Questions about this notice regarding protected health information may be directed to: Compliance Officer, RVPCS P.O. Box 130, Ratliff AR 72951.

Each visit to the clinic is documented in your PHI and will contain symptoms, examination, test results, diagnosis, and plan.

HOW RVPCS MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION [PHI]:
I. Plan of care and treatment may require disclosure to a testing laboratory or pharmacy for prescription in addition to our own healthcare personnel or to other health care providers for purposes related to your care and treatment. PHI may also be disclosed to those involved in your care, spouse, children, or parents.

II. PHI may be used by RVPCS to bill and collect payment for services provided to you. This may include contacting your insurance carrier for coverage verification, providing information to obtain authorization to treat under your insurance coverage, to obtain third party payments on behalf, or to bill you directly for services provided in our clinic. Your PHI may be provided to other health care providers and entities to assist in their billing efforts when providing services on your behalf.

III. RVPCS may use and disclose your PHI as part of business operations to evaluate services, cost management efforts, business planning, or appointment reminders for example.

IV. PHI will be disclosed as required by federal, state, or local law. Such disclosures may include health oversight governances for audits, credentialing, licensure, criminal or civil actions, abuse, neglect, or domestic abuse concerns or compliance issues.

V. RVPCS may disclose PHI to public health authorities authorized to collect information under law to protect the common good and community interest.

VI. Other PHI disclosure may be for Workman's compensation and other similar programs; to custodial correctional facilities, and for reasons of national security.

VII. RVPCS may disclose PHI to business associates contracted for specific business operations related to either your care and treatment or the conduct of our business. Contracted business associates are held to the same compliance with PHI as held by RVPCS.

OUR RIGHTS REGARDING THE PROTECED HEALTH INFORMATION [PHI] RVPCS MAINTAIN ABOUT YOU
I. You have the right to decide how confidential communication will be managed or disclosed and RVPCS will strive to honor reasonable request. You may complete a request to limit or restrict disclosure of your PHI. You may request in writing how and to whom PHI may be communicated. This written authorization may detail preferred method of contact and how that contact should be made in clear, concise writing: however, RVPCS does not have to agree to unreasonable restriction that may prevent conduct of its business or compliance with applicable state, federal or local laws. You may change disclosure information by written request at any time.

II. Your health care record is the property of RVPCS; however, you have the right to inspect and obtain a copy of the PHI, excluding psychotherapy notes, used in treatment plan decisions. This inspection or copy must be requested in writing to Medical Records. P.O. Box 130, Ratcliff AR 72951. Fees for the cost of copying, mailing, labor and other supplies may be applied. In certain limited circumstances request to inspect or review may be denied. You may submit in writing a request for a review of our denial with RVPCS reserving the option to select a health care professional of its choosing to conduct the review.

III. You may submit in writing a request to have your health information amended if you believe it is incomplete or incorrect. The submitted information must include reasons that support the amendment request. RVPCS will deny request to amend information that in the opinion of the provider is accurate or complete, does not pertain to PHI in our record, or the PHI was created by another practice.

IV. You have the right to request an accounting of non-routine disclosures made by RVPCS which are unrelated to routine patient care and clinic operations. Request must be submitted in writing to Medical Records, P.O. box 130, Ratcliff AR 72951 and identified a specific time period. You will be notified of cost of accounting disclosures requested more than once a year.

V. Other PHI rights include receiving a copy or our privacy policy at any time. You have the right to file a complaint if you feel your privacy rights have been violated with Compliance Officer, RVPCS P.O. Box 130 Ratcliff AR 72951 or the Secretary of the Dept. of Health and Human Services.

ELECTRONIC MEDICAL RECORD:
To comply with recommended health industry practices, River Valley Primary Care Services, Inc. adopted an electronic medical record (EMR) as the method to chart and maintain your PHI. The system used, Epic, is compliant with all CMS required standards and is primarily protected by a tiered password system. A secondary security measure is provided through specific, defined accessibility to charted information dependent on employee job responsibilities with limitation based on assigned job task and need to know.