COMMUNITY
HEALTH CENTER
Of The New River Valley

Welcome to your Health Care Home!

Thank you for choosing our Community Health Center as your Health Care Home. As your Health Care Home, you will be asked to select a primary provider, who will oversee all of the care you receive. That provider is assisted by a care team made up of nurses and other support staff. Your care team will coordinate your health care throughout all settings inside and outside of our Community Health Center to promote better health for you, our patient.

We provide the highest quality of health care, based upon current medical, dental, and behavioral health research, standards, and protocols. We provide integrated care so that all of your providers work together to provide comprehensive and holistic care that considers every aspect of your health. We will involve you in the decisions made on your behalf.

As a Health Care Home, we function best when we have your complete medical history and information about health care obtained by other providers outside of this Health Center. We will always ask you for updates about other medical, dental, and mental health care you have received, so we can stay up to date and provide the most appropriate and continuous service possible.

Also as a Health Care Home, we provide timely clinical advice on the telephone and via a secure web-based Patient Portal, both during office hours and when the office is closed. Instructions for obtaining care and clinical advice using the telephone and Internet are included in this welcome packet.

At our Center, no one is denied service due to an inability to pay. Persons with limited income may qualify for our Sliding Fee Scale. Please inquire.

Montgomery Center
215 Roanoke Street, Christiansburg, VA 24073
Ph: 540-381-0820
Hours: 8:00—5:00 Monday-Friday
Also 5:00—7:00 pm Thursday evenings

Giles Center
219 Buchanan Street, Pearisburg, VA 24134
Ph: 540-921-3502
Hours: 8:00—5:00 Monday-Friday

Pulaski/Radford Center
5826 Ruebush Road, Dublin, VA 24084
Ph: 540-585-1310
Hours: 8:30—5:00 Monday-Friday

After-Hours Call Service for All Sites:
540-251-0250

We provide the following services to people of all ages:

- Primary Health Care
- Check-ups, Preventive Care
- Chronic Disease Management
- Care Coordination and Referrals
- Well Child Visits, Vaccinations
- Behavioral Health Services
- Medication Assistance
- General Dentistry, including extractions, cleaning, fillings, crowns, bridges, and dentures
- Insurance Assistance, with the Federal Health Insurance Marketplace, Medicare, Medicaid, and FAMIS

A Language Line is available for patients who need translators.

The mission of the Community Health Center of the New River Valley is to provide affordable and high quality medical, dental, behavioral and preventive health services to people of all ages and circumstances, regardless of ability to pay or insurance status.

Notice of Privacy Practices

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

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director

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

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to amend your medical record

- You can ask us to amend health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice - You can ask for a paper copy of this notice at any time.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will ensure the person has this authority before we take any action.

Your Choices

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

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Most sharing of psychotherapy notes
- Sale of your information

In the case of fundraising we may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

We typically use or share your health information in the following ways.

We can use your health information and share it with other professionals who are treating you.

We can use and share your health information to run our practice, improve your care, and contact you when necessary. We can use and share your health information to bill and get payment from health plans or other entities.

Electronic Exchange. Your information may be shared w/ other providers, labs and radiology groups through our EHR system as listed:

1) Lab Corp 2) Open Dental

How else can we use or share your health information?

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

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Preventing or reducing a serious threat to anyone's health or safety
- Helping with product recalls
- Reporting suspected abuse, neglect, or domestic violence
- Reporting adverse reactions to medications

Do research, Comply with the law, Respond to organ and tissue donation requests, Work with a medical examiner or funeral director.

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions as military, national security, and presidential protective services

Respond to lawsuits and legal actions

Our Responsibilities

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

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

Changes to the Terms of this Notice

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

You Have A Right To File A Complaint If You Feel Your Privacy Has Been Violated

- If you feel your Privacy Rights have been violated, please ask our staff for a Privacy Complaint Form. Our Security Officer will review the form and promptly notifiy you of the actions our office will take.
- or You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting http://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html
- We will not retaliate against you for filing a complaint.

Community Health Center of the New River Valley
HIPAA Compliance Officer: Ashley Slagel-Perry
Phone: 540-381-0820

This Notice of Privacy Practices is effective March 1, 2017

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

Community Health Center of the New River Valley complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Our practice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Community Health Center of the New River Valley, provides at no cost aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters, written information in other formats (large print, audio, accessible elec. formats, other formats). Provides at no cost language services to people whose primary language is not English, such as: qualified interpreters; information written in other languages. If you need these services please tell our front desk or any staff member.

If you believe our practice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator: Ashley Slagel-Perry, 215 Roanoke Street, Christiansburg, Virginia 24060, 540-381-0820. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201. 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/civil-rights/filing-a-complaint/index.html

Proficiency of Language Assistance Services

ATTENTION: If you speak any of the languages below, language assistance services, free of charge, are available to you.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số.

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PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa

ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم رقم: .والبكم الصم ه

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod Numer.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。

توجه :اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما .بگیرید تم

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche.

OUR HEALTH CARE PROVIDERS

MEDICAL PROVIDERS

Abraham Hardee, DO, PhD

Sarah Turner, DO, CAQSM

Linda Morrow, MD, GYN

Chuck Smith, FNP

Morgan Akers, FNP

Tony Ramsey, FNP

BEHAVIORAL HEALTH PROVIDERS

Ashley Slagel-Perry, LCSW

Melissa Hunt, PhD, LCP

Erin Shaffer, LCSW

DENTAL PROVIDERS

Catherine Mansdoerfer, DDS

Marie Joseph, DDS

Mona Semtner, DDS

Brittany Steiner, RDH

Brenda Price, RDH

Welcome to the Community Health Center of the New River Valley!

Thank you for choosing our Community Health Center as your Medical and/or Dental Home.

Keep this Welcome Packet handy. It includes the forms you may need to complete. It also includes other important information that may be helpful as you join our Medical Home, and later as your health care needs change. Included here are:

- ○ Patient Registration Form
- ○ Acknowledgements and Authorizations Form
- ○ Information on obtaining After-Hours Clinical Advice
- ○ Health History Form
- ○ Behavioral Health Integrated Care Information and Acknowledgement Form
- ○ Information on our Language Line (for non-English speaking patients)
- ○ Information on how to access information on Health Insurance Marketplace options
- ○ Our No Show Policy
- ○ Authorization for Use and Disclosure of Protected Information
- ○ Notice of Privacy Practices (HIPAA)
- ○ Dental Health History Form (for dental patients only)
- ○ General Dentistry Consent Form (for dental patients only)

And, for those patients who want to transfer their medical records to us from another provider, or want us to send medical records to another provider:

- ○ Records Transfer Request Form

And, for those patients who would like to apply for our Sliding Fee Discount Schedule (reduced fees based upon income and family size):

- ○ Household Financial Information Form

I have reviewed the information in the Welcome Packet, and have been given the opportunity to discuss it with a staff person.

Name (Print): _____ ***Date:*** _____

Signature: _____

Patient Appointment No-Show Policy

Last minute "No-Shows" and cancellations for medical appointments can be a problem for all practices. Many practices purposefully overbook appointments or charge the patient for a No-Show so that No-Shows and cancellations won't limit access for other patients or cause a financial hardship for the practice.

If you are going to be late, we ask that you call ahead to determine if we can still accommodate you. We typically allow patients a 10-minute grace period for late arrivals but after this time a patient is considered a No-Show for the appointment. If you are unable to keep your appointment, please call to cancel or reschedule by 3pm of the prior business day* to avoid a No-Show appointment.

After three (3) No-Show appointments within a calendar year, patients will receive a letter stating they will need to schedule a face-to-face session with the Site Manager or designee to discuss their No-Show appointments before they can schedule another appointment.

**Monday appointments must be rescheduled or cancelled by 3pm on the Friday before.*

Community Health Center of the New River Valley

Patient Registration Form

First Name:_____

Last Name:_____

Date of Birth:_____

Social Security #: _____

Address:_____

City:_____

State & Zip Code:_____

Email Address: _____

Home Phone:_____

Cell Phone:_____

Work Phone:_____

Preferred Method of Contact (circle):

Home Phone Cell Phone Text Message Email

Occupation: _____

Sex: Male Female Other

Sexual Orientation (circle):

Straight (not lesbian or gay) Lesbian/Gay Bisexual

Something Else Don't Know Choose not to disclose

Gender Identity (circle): Male Female

Transgender Male/Female-to-Male Other

Transgender Female/Male-to-Female Choose not to disclose

Marital Status:_____

Are you a (circle one):

U.S. Citizen U.S. Resident Other

Are you a United States Veteran? Yes No

What is your primary language? _____

Do you require an interpreter? Yes No

Race (select all that apply):

____African-American ____Native American

____Asian ____Pacific Islander

____Caucasian ____Other

Ethnicity (select one):

____Hispanic ____Non-Hispanic

Emergency Contact Information:

Name:_____

Relationship to Patient: _____

Address:_____

City:_____

State & Zip Code:_____

Home Phone:_____

Cell Phone:_____

Billing Information: It is important that you provide us with complete and accurate information (i.e. home address, phone numbers) so that we may properly submit billing data to your insurance company. We will make every effort to submit claims to your insurance company and promptly provide you with our statements. However, if for any reason the statement is returned to our office because of a problem with an address you provided, we will call you to secure full payment. Please ensure that all of your information is accurate and up-to-date. Please be sure to bring your photo identification and your insurance cards to every visit so that we may properly bill your insurance company. If you do not have your insurance card with you, you may be required to make payment in full that day.

Primary Insurance Company Information

Company:_____

Subscriber/Policy/Medicare/Medicaid Number:_____

Group Number:_____

Primary Policy Holder Information

Policy Holder Name:_____

Policy Holder DOB:_____

Relationship to Patient:_____

No Insurance Coverage:

I currently do not have any medical insurance or pharmacy prescription coverage, whether through the government (Medicare or Medicaid), employment, or a private company. When I receive insurance coverage or pharmacy prescription coverage, I will notify the Community Health Center within 30 days of the start date of the new insurance and will provide a copy of my card.

Initial here: _____

By signing below, I am acknowledging that the above information is true and accurate to the best of my knowledge. I also attest that if it is found that I am knowingly withholding insurance information and the time frame to file previous claims has been exceeded, I will be held responsible for any past due amounts.

Signature of Patient or Legal Guardian: _____ Date:_____

Community Health Center of the New River Valley

Health History Form

Last Name:	First Name:	Date of Birth:

Current Medications: Please include Non-Prescription, Herbal Medications, and Vitamins

Medication Name/ Strength	Medication Name/ Strength

Are you Allergic to: Latex Aspirin Metals Codeine Sulfa Penicillin Tetracycline Erythromycin Dental Anesthetics Other:

Medical Illnesses or Conditions

CONDTION	ONSET DATE	CONDTION	ONSET DATE	CONDITION	ONSET DATE
☐ Anxiety	_____	☐ GI Issues	_____	☐ Muscular/Skeletal	_____
☐ Arthritis	_____	☐ Glaucoma/Cataracts	_____	☐ Osteoporosis	_____
☐ Asthma/COPD	_____	☐ Heart Attack	_____	☐ Seizures	_____
☐ Cancer	_____	☐ Heart Catheterization	_____	☐ STD's	_____
☐ Depression	_____	☐ Heart Murmur	_____	☐ Stroke	_____
☐ Diabetes/ Sugar	_____	☐ High Blood Pressure	_____	☐ Thyroid Disorder	_____
☐ Diabetic Neuropathy	_____	☐ High Cholesterol	_____	☐ Joint Replacement	_____
☐ DVT/ Clotting	_____	☐ HIV	_____		
☐ Dry Skin	_____	☐ Liver Disease	_____	☐ Other	_____

Surgical History

SURGERY	YEAR

List any hospitalizations in the last 10 years: (Date, Hospital, Reason)

Social History

Tobacco Usage	Alcohol Usage	Exercise
Do you Smoke? Yes/ No # of packs a day_____ How many years? _____	Do you consume Alcohol? Yes/ No # of drinks per day _____	Do you regularly exercise? Yes/ No Describe:

Are you currently under the care of another physician, specialist, or dentist? YES / NO

If yes, name of provider: _____

If yes, date you last saw this provider: _____

If yes, do you plan to transfer your care to this clinic? YES / NO

If yes, please fill out a release of information (ROI) form and give to the Patient Assistance Coordinator.

Female Only:

Are you pregnant? YES / NO

How many pregnancies? _____ Number of living children? _____

Signature of Patient or Legal Guardian: _____ Date:_____

Community Health Center of the New River Valley

Acknowledgments and Authorizations Form

Patient Name_____ **SS#**_____ **Birthdate**_____

Sign your initials next to each section:

_____**CONSENT FOR TREATMENT:** I authorize the employees, agents and staff of the Community Health Center to perform and hereby consent to such medical treatment and examinations, including diagnostic procedures or behavioral health evaluations, as may in the opinion of the patient's physician be necessary.

_____**NO GUARANTEE:** I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of any procedures, treatments or examinations.

_____**FINANCIAL RESPONSIBILITY:** I understand that I am financially responsible for all charges, whether or not paid by insurance. The Community Health Center does not participate in **EVERY** insurance plan. I understand that I am responsible for verifying that the Community Health Center provider is a participating provider in my insurance plan. Payment is expected at the time of service.

_____**RELEASE OF INFORMATION:** I authorize the center to release any and all patient medical and billing information to any physician involved in my treatment; to any healthcare facility to which I/the patient is discharged or transferred to for treatment, billing, quality assurance, collection, or defense of litigation or anticipated litigation; and to any insurance company, review organization or other entity, which is directly or indirectly responsible for payment or review of services provided by the Community Health Center. I consent to use and/or disclosure of my protected health information to carry out treatment, payment or healthcare operations by the Community Health Center.

_____**DEEMED CONSENT FOR BLOOD TESTING:** I understand that under Virginia Law, if a healthcare provider, a person employed by, under the direction of, or control of a healthcare provider, is directly exposed to body fluids of a patient, which may transmit viruses causing HIV or Hepatitis B or C, the patient will be deemed to have consent for testing for HIV or Hepatitis B or C, and to the release of such test results to the person who was exposed. (Exposure could occur due to an accidental needle stick.) A patient who tests positive will be afforded the opportunity for individual face-to-face disclosure of test results and appropriate counseling.

_____**SLIDING FEE SCALE:** Qualifying for our sliding fee scale based on your family income and family size may result in lower charges. You are required to report any income and family size changes to us as this may impact the amount you are expected to pay. We will review and update your information annually. Eligibility cannot be determined until we receive all requested information. **If it is determined you are not eligible for a sliding fee and you have incurred charges, you will be expected to pay the balance due.** We will assist you by arranging a payment plan if needed. You will be asked to pay a minimum fee for your first visit until the sliding fee eligibility process is complete. The remaining cost of the first and subsequent visits will be based on the outcome of this determination. If you do not pay for services at the time they are rendered, your balance must be paid in full within ninety (90) days.

_____**MEDICARE LIFE-TIME/MEDICAID SIGNATURE AUTHORIZATION AND ASSIGNMENT:** I request that payment of authorized Medicare/Medicaid benefits be made on my/the patient's behalf of any services furnished by or in the center, including physician services. I authorize any holder of medical or other information about me, to release to the Community Health Center for Medicare and Medicaid services, the Virginia Department of Medical Assistance Services and their agents, any information needed to determine these benefits or benefits for related services. I assign the benefits payable for physician and other medical services claims to Medicare and/or Medicaid for payment. I understand that I/the patient am responsible for any deductibles, co-payments and any applicable percentage of remaining charges.

_____**CERTIFICATION AND ACKNOWLEDGEMENT:** I certify that all of the above information and all information supplied by me, as part of the registration process is correct. I also acknowledge receipt of the Community Health Center's Notice of Privacy Practices (HIPAA).

_____ _____

Patient or Parent/Legal Guardian Date

_____ _____

Relationship to Patient Witness Signature

Informed Consent for Integrated Care Services

I hereby agree to Integrated Care services through the Community Health Center of the New River Valley.

I understand that my physician/nurse practitioner may make a referral to behavioral health services and discuss my medical care and behavioral health concerns with the Integrated Treatment Care Coordinator when necessary. I understand that my physician/nurse practitioner will ask for my permission before conducting the consultation/referral process and will inform me about what was discussed if I am not able to meet with the Integrated Treatment Care Coordinator on the day the referral was made. I understand that beginning any counseling or psychiatric services is my choice and initiation of services will be discussed directly with me by the Integrated Treatment Care Coordinator.

I understand that all information regarding services is confidential and will not be released to any other agency or individual without my knowledge and consent, except when required by law (such as abuse and/or neglect of a person who is presently a minor or elderly, and/or serious intent of harm to self or others).

I have been given a full explanation of Integrated Care Services at the Community Health Center and I agree to the guidelines stated in this document.

_____

Name of Patient or Legal Guardian (Please Print)

_____ _____

Signature of Patient or Legal Guardian Date

Dental Health History

Patient's Name:_____ Date:_____

Birthdate: ____/____/____ Age: ____ Sex (circle one): Male or Female

When was your last dental visit? _____

What was the reason for your last visit?

_____

Do you brush daily? YES or NO times per day:_____

Do you floss daily? YES or NO times per day:_____

Do you have a specific dental problem or concern?

_____

_____

_____

_____

How would you rate your current dental health? ☐ Good ☐ Fair ☐ Poor

Are you currently in discomfort? YES or NO

Have you been to the ER in the last year for dental issues? YES or NO

If yes, when and where did you go?

_____

Have you gone to the ER several times for the same problem? YES or NO

If yes, how many times? _____

Do you have Osteoporosis? YES or NO

Do you have a history of taking Bisphosphonates? (Bisphosphonates are prescription drugs that are commonly used to treat Osteoporosis, like Boniva or Fosamax) YES or NO

Do you require antibiotic pre-medication prior to dental work? YES or NO

Do you have tooth sensitivity to:

☐ heat ☐ cold ☐ sweet ☐ discomfort when biting

☐ recurring sores or blisters in/on your mouth, tongue, lips, etc.

GENERAL DENTISTRY INFORMED CONSENT FORM

COMMUNITY HEALTH CENTER
Of The New River Valley

1. **EXAMINATION AND X-RAYS**
   I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.

2. **DRUG, MEDICATION, AND SEDATION**
   I have been informed and understand that antibiotics, analgesics, and other medications can cause allergic reactions, causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased using alcohol or other drugs. I understand that and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infections, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives, i.e. birth control.

3. **CHANGES IN TREATMENT PLAN**
   I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions as necessary.

4. **FILLINGS**
   I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage, and tooth sensitivity is a common after-effect of a newly placed filing.

5. **REMOVAL OF TEETH (EXTRACTION)**
   Alternative to removal has been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for the reasons in paragraph #3. I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, and spread of infection; dry socket; loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia) that can last for an indefinite period of time; or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

6. **CROWNS, BRIDGES, VENEERS AND BONDING**
   I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crowns, bridge or cap (including shape, fit, size, placement, and color) will be done before cementation. It has been explained to me that, in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

7. **DENTURES—COMPLETE OR PARTIAL**
   I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including, shape, fit, size, placement, and color" will be "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not the initial denture fee.

8. **ENDODONTIC TREATMENT (ROOT CANAL)**
   I realize there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

9. **PERIODONTAL TREATMENT**
   I Understand that I have a serious condition causing gum inflammation and/or bone loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery and/or extractions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, follow a healthy a healthy diet, avoid tobacco ad follow other recommendations.

10. **TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ)**
    I understand that symptoms of popping, clicking, locking, and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost is my responsibility.

CONSENT: *I understand that dentistry is not an exact science; therefore, reputable providers cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorize. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating Dentist is responsible for my dental treatment.*

Signature: _____ Date: _____

Community Health Center of the New River Valley

Household Financial Information Form

How many people are in your family? _____
Please list them below, with the required information for each.

Family Members: (include yourself)	SSN:	Date of Birth:	Relation	Monthly Gross Income*	Employer Name (If employed)

***If someone can claim you as a dependent on their taxes, then list all other family members on that tax return.**

Document and provide proof of all income received: Paycheck stubs, Retirement, Social Security, Pension, Disability, Worker's Compensation, Unemployment, Child Support, and ALL others not listed. **Application will be rejected if documentation is not provided.**

Employment Information

Employer Information

Employer: _____
Date Employment Began:_____
Employer Phone:_____

Circle One: Full-Time Part-Time

Income Information

How often are you paid? _____

Amount you are paid:_____

Unemployment Information

If Unemployed, date employment ended:_____
Does anyone receive unemployment wages? If yes, how much?_____

Disability Information

If Unemployed, has anyone applied for Disability? Yes / No
Is anyone in your family planning on applying for disability? This includes you. Yes / No

Government Assistance Information

Medicaid? Yes / No Who?_____

Do you/spouse or any children under 18 receive Social Security Benefits? Yes / No

Insurance Information

Do you or others in the family have insurance? Yes / No

Personal Information

Child Support received:_____

Alimony received:_____

Did your household file income taxes last year? Yes / No

Joint or Single? Circle One.

The information provided is, to the best of my knowledge and belief, accurate and true. I authorize the release of all information which the Community Health Center may need to determine whether I qualify for financial assistance through their Sliding Fee Discount Program.

Signature of Patient or Legal Guardian: _____ Date:_____

Application for Sliding Fee Discount Program

Welcome to the Community Health Center of the New River Valley. We offer affordable health care and dental care through the use of a Sliding Scale Fee to all patients at or below 200% of the poverty level. In order to process your application efficiently and avoid delays in your future health care, please follow the guidelines below.

1. **The application must be completely filled out before coming to the office for your initial scheduled appointment.**

2. **Please complete the attached Household Financial Information Form. You are required to bring proof of ALL income that is received in your household. This may be in the form of the following:**
   a. **Paycheck stubs for most recent full month of work;**
   b. **A copy of your Disability Determination letter;**
   c. **A copy of your Unemployment or Workers Compensation letter;**
   d. **A copy of your benefit letter from the Social Security Administration or other retirement fund;**
   e. **Documentation of any child support or alimony payment received;**
   f. **Documentation of income from any other source. (Note: Food Stamps do NOT count as income.)**

   In addition, a copy of your household's federal INCOME TAX RETURN and W-2 for the most recent year is required. If your family did not file federal income tax, you will need to complete a form declaring that you did not file taxes. This will be verified with the IRS.

3. **If there is no income in your household, we require the completion of a Letter of Support, signed by the person who provides basic necessities for you, such as food and shelter. PLEASE NOTE: If this person listed you as a dependent on his/her income taxes last year, you are a member of that household, and therefore all income in that household must be considered.**

YOUR INITIAL APPOINTMENT WITH ELIGIBILITY SPECIALIST

In addition to the income documentation above, the following information is required for all patients:

- Your driver's license or other photo ID.
- Your completed Patient Registration Form and Health History Form.
- Your insurance card if you have insurance.

Prior to your first visit, you will briefly meet with an Eligibility Specialist who will review your application and determine if you are eligible for our Sliding Fee Discount Program. At this time, the Eligibility Specialist will answer any questions you may have regarding the Sliding Fee Discount Program.

Our Eligibility Specialists are available Monday-Friday if you want to determine your approximate fee prior to the appointment, or if you need any type of assistance in becoming a patient at this Community Health Center.

Sliding Fee Discount Program
Medical Services

All patients (insured and uninsured) may apply for the Sliding Fee Discount Program. Even if you have insurance, you may qualify for discounts on charges under our Sliding Fee Discount Program based on your annual income and family size. This discount may be applied to the full fee or any deductible or co-insurance. The Sliding Fee Discount is good for one year. You will need to reapply annually.

Eligibility cannot be determined until we receive all requested information from you. If it is determined that you are not eligible for a sliding fee and you have incurred charges, you will be expected to pay the balance due.

Individuals at or below 100% of Federal Poverty Guidelines:

Household Size	Family Income Below:	
1	$12,060	NOMINAL $20.00 Per Visit
2	$16,240	
3	$20,420	
4	$24,600	

Individuals between 101% and 125% of the Federal Poverty Guidelines:

Household Size	Family Income Below:	
1	$15,075	$25.00 Per Visit
2	$20,300	
3	$25,525	
4	$30,750	

Individuals between 126% and 150% of Federal Poverty Guidelines:

Household Size	Family Income Below:	
1	$18.090	$30.00 Per Visit
2	$24,360	
3	$30,630	
4	$36,900	

Individuals between 151% and 200% of the Federal Poverty Guidelines:

Household Size	Family Income Below:	
1	$24,120	$35.00 Per Visit
2	$32,480	
3	$40,840	
4	$49,200	

Sliding Fee Discount Program
Behavioral Health Services by Center Staff

All patients (insured and uninsured) may apply for the Sliding Fee Discount Program. Even if you have insurance, you may qualify for discounts on charges under our Sliding Fee Discount Program based on your annual income and family size. This discount may be applied to the full fee or any deductible or co-insurance. The Sliding Fee Discount is good for one year. You will need to reapply annually.

Eligibility cannot be determined until we receive all requested information from you. If it is determined that you are not eligible for a sliding fee and you have incurred charges, you will be expected to pay the balance due.

Individuals at or below 100% of Federal Poverty Guidelines:

Household Size	Family Income Below:	
1	$12,060	NOMINAL $10.00 Per Visit
2	$16,240	
3	$20,420	
4	$24,600	

Individuals between 101% and 125% of the Federal Poverty Guidelines:

Household Size	Family Income Below:	
1	$15,075	$15.00 Per Visit
2	$20,300	
3	$25,525	
4	$30,750	

Individuals between 126% and 150% of Federal Poverty Guidelines:

Household Size	Family Income Below:	
1	$18.090	$20.00 Per Visit
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Individuals between 151% and 200% of the Federal Poverty Guidelines:

Household Size	Family Income Below:	
1	$24,120	$25.00 Per Visit
2	$32,480	
3	$40,840	
4	$49,200	