Cow Creek Health and Wellness Center

2589 NW Edenbower Blvd., Roseburg OR | (541) 672-8533 - Opt #2
480 Wartahoo Ln., Canyonville OR | (541) 672-8533 - Opt #3
500 SE Cass Ave, Suite 110, Roseburg OR | (541) 672-8533 - Opt #4

For Clinic Use
Date Received:
Received by:
Patient #

New Patient Adult Registration Form

To which clinic campus are you applying as a patient? (please check one)

◯ North campus (Roseburg) ◯ South campus (Canyonville)

Requested Provider: _____

Social Security Number: _____ Patient's Preferred Name: _____

Patient's Legal First Name: _____ Middle Initial: _____

Patient's Legal Last Name: _____ Suffix: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Gender assigned at birth: ◯ Male ◯ Female Gender patient identifies as: _____

Sexual orientation: _____ Date of Birth: _____ Marital status: _____

Ethnicity (please check the boxes that best apply)

☐ American Indian/Alaskan Native ☐ African American ☐ Asian ☐ Caucasian
☐ Native Hawaiian/Other Pacific Islander ☐ Other (please specify): _____

Are you enrolled in a Tribe? ◯ Yes ◯ No If yes, which Tribe? _____

Tribal Enrollment Number: _____ Are you a veteran? ◯ Yes ◯ No

Preferred Pharmacy: _____

Primary language: _____

Would you like an interpreter to help you overcome a language barrier? ◯ Yes ◯ No ☐ Sign Language

Cell phone #: _____ Home phone #: _____

Preferred method of contact (please check best answer):

◯ Home phone ◯ Cell phone ◯ Email ◯ Other (please specify): _____

If you would like to be a part of our online Patient Portal, please provide your email address:

_____

How were you referred to us?

For Clinic Use
Date Received:
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Patient #

New Patient Adult Registration Form

Employment status (please check box that best applies)

◯ Employed ◯ Self-employed ◯ Disabled ◯ Full-time student ◯ Part-time student

◯ Other: _____

Employer: _____ Employer's phone number: _____

If you are employed by a Tribe, which department or business? _____

If you wish to share your financial information, you may qualify for a sliding fee scale for reduced cost services.

Houshold income: _____ ◯ Annual ◯ Monthly

Number of persons living in your household: _____

Primary Insurance: ◯ Yes ◯ No Insurance Name: _____

Insured ID: _____ Group: _____

Name of Policy Holder: _____ Policy Holder Date of Birth: _____

Secondary Insurance: ◯ Yes ◯ No Insurance Name: _____

Insured ID: _____ Group: _____

Name of Policy Holder: _____ Policy Holder Date of Birth: _____

I, the undersigned, being the patient or legal guardian/person having legal custody/or person otherwise having legal authorization to consent, freely give my consent to Cow Creek Health and Wellness Center and their agents, to examine and treat the patient registered / referenced above.

By signing this form, I verify that the information provided is true and factual to the best of my knowledge.

Printed name of patient or patient's legal representative _____ **Relationship to patient** _____

Signature of patient or legal representative _____ **Date** _____

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Informed Consent for Treatment

Welcome to Cow Creek Health and Wellness (CCH&W). We hope that your experience with us will be positive, and that our assistance will be beneficial to you on your journey.

Consent for Treatment

I hereby voluntarily request and authorize Cow Creek Health & Wellness Center (CCH&WC), including its affiliated, providers, physicians, technicians, nurses, and other qualified personnel, as well as appropriately supervised students, to perform evaluation, treatment services, and medical procedures as may be deemed necessary. This authorization is given in accordance with the judgment of the attending medical practitioner(s) responsible for my care.

Treatment of Minor Children

I understand that minor child's patients must be accompanied by a parent or legal guardian at all times while at CCH&WC. I acknowledge that charges for services rendered to minor children are the responsibility of the guardian who seeks treatment for the child and are due at the time of service(s).

Photography / Video Consent

I acknowledge that my photograph may be taken for chart identification and documentation purposes for my electronic health record and is the property of CCH&WC unless I withdraw my consent in writing. I consent to videotaping for telehealth appointments for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations. I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

Insurance Authorization and Assignment

I request that payment of authorized medical benefits be made on my behalf directly to the CCH&WC provider of service(s) furnished to me. I authorize CCH&WC to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employers, or group health insurance plan, directly to CCH&WC. I hereby authorize photocopies of this form to be valid as the original.

Electronic Health Record Consent

I understand that healthcare providers require access to patient medical information at all times and locations where a patient presents for care to ensure safety, quality, and to coordinate patient care across the provider network, avoiding duplication of services. CCH&WC maintains a system-wide electronic medical record accessible on a "need to know" basis for sharing information about patient care in various settings. I give permission to share my electronic medical record among my healthcare providers and to obtain medication history through a Provider Health Information Exchange (HIE).

Notice of Privacy Practices Acknowledgement

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have been offered a copy of the CCH&WC's Notice of Privacy Practices. I consent to the use and disclosure of my protected health information as described therein. This includes information generated through virtual health services and all medical information generated during hospitalization and outpatient treatment at CCH&WC.

Acknowledgment of Understanding

By signing below, I certify that I have read and fully understand the above statements, and I consent fully and voluntarily to the medical treatments as described above.

Printed name of patient or patient's legal representative _____ **Relationship to patient** _____

Signature of patient or legal representative _____ **Date** _____

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Permission to Speak with Designated Person(s)

Please note that this form is NOT a release for medical records.

Print Patient's Name: _____

Please provide a list of all the parties we may speak with or leave a detailed message with regarding the patient's care, including health issues, HIV/Sexually Transmitted Diseases (STD) related records, appointment scheduling, or payment information. Use another form for additional parties.

Please initial next to MEDICAL (MED), BEHAVIORAL HEALTH (BH), HIV/STD to allow permissions:

Emergency Contact (first and last name): _____

Relationship to Patient: _____ **Phone Number**: _____

Allowed to be given the following related information (please initial): **MED** _____ **BH** _____ **HIV/STD** _____

Permission to speak to (first and last name): _____

Relationship to Patient: _____ **Phone Number**: _____

Allowed to be given the following related information (please initial): **MED** _____ **BH** _____ **HIV/STD** _____

Permission to speak to (first and last name): _____

Relationship to Patient: _____ **Phone Number**: _____

Allowed to be given the following related information (please initial): **MED** _____ **BH** _____ **HIV/STD** _____

- **Signing below indicates that Cow Creek Health & Wellness staff are authorized to contact these individuals from the date of the signature below until the patient notifies staff otherwise.**
- **If they cannot contact you, may Cow Creek Health & Wellness staff leave a message on your answering machine or voice mail?** (please initial) Yes _____ No _____
- **Please verify YOUR phone number (s) for our records:** _____
- **May Cow Creek Health & Wellness contact you at work?** (please initial) Yes _____ No _____
- If you initialed yes, please list your work phone number: _____

By signing, I authorize the staff of Cow Creek Health & Wellness Center to speak with the above person(s) about my health and healthcare as indicated above. I understand that this permission shall remain in effect as indicated above or until I revoke it in writing.

Printed name of patient or patient's legal representative _____ **Relationship to patient** _____

Signature of patient or legal representative _____ **Date** _____

Late Patient, Late Cancellation, and No-Show Policy

It is the policy of CCH&WC to offer accessible services. In order to do so, we need all patients to share in the responsibility of managing their appointments. Cow Creek Health & Wellness Center will contact you by your preferred method of choice to remind you of upcoming appointments. When a patient does not show up for an appointment, cancels with less than 24 hours' notice, or is late, the impact is felt by other patients and the organization as a whole.

Please be aware of the following concerning late patients, late cancellations, and no-shows:

1. **Late:** If a patient is late up to 10 minutes, the clinic can try to accommodate the patient. However, the patient will be told that they may need to wait to be seen, that the appointment may be brief, or potentially rescheduled for a different day. The patient is encouraged to call if they are going to be late. Calling will not guarantee an appointment. All late offenses will be documented in the patient's chart. Three consecutive late appointments in a one-year period of time will result in escalation to the provider for further action.
2. **Cancellation:** CCH&WC requests that patients give our clinic 24 hours notice in the event the appointment needs to be canceled or rescheduled. If transportation is a barrier, our clinic can offer a telemedicine visit using video technology, depending upon the purpose of the visit. The patient will be asked if they are interested in this option when calling to cancel. If the patient does not call our clinic to cancel/reschedule the appointment in the time allotted, the clinic will apply the following. Three consecutive cancelations without 24-hour notice in a one-year period of time will result in escalation to the provider for further action.
3. **No-Show:** CCH&WC requests that patients call and cancel so that another patient can fill that appointment spot.
    a. **First No-Show:** After a patient's first no-show, a phone call will be made to reschedule their appointment, and a reminder letter will be sent.
    b. **Second No-Show:** After a patient's second no-show, a second warning letter will be sent.
    c. **Third No-Show:** Upon a third no-show, the patient may face scheduling restrictions, up to and including potential dismissal from the practice, at the discretion of clinic administration.

*Behavioral Health and Substance Use Disorder patients may receive alternative communication from the clinic.

By signing below, I indicate that I have read and understood the Cow Creek Health & Wellness Center's Late Patient, Late Cancellation, and No-Show Policy, and that I am in agreement with this policy:

Printed name of patient or patient's legal representative _____ **Relationship to patient** _____

Signature of patient or legal representative _____ **Date** _____

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Authorization to Release Protected Healthcare Information to Cow Creek Health and Wellness Center

Patient Name: _____ **Previous Names:** _____

Date of Birth: _____ **Social Security Number:** _____ **Phone Number:** _____

MINORS: A minor patient's signature is required in order to release the following information: (1) conditions relating to the minor's reproductive care, including, but not limited to: contraception, pregnancy and pregnancy termination, sterilization, and sexually transmitted diseases (ages 14 and older); (2) alcohol and/or drug abuse (age 13 and older); and (3) mental health conditions (age 13 and older).

I request and authorize: _____ _____
(Name of clinic sending information) (Fax number of clinic sending information)

To release healthcare information about the above-mentioned patient to:

Name: Cow Creek Health and Wellness Center

Address: 2589 NW Edenbower Blvd., Roseburg, OR 97471

Phone: (541) 672-8533 **Fax:** ◯ North Clinic (855) 670-1788 ◯ South Clinic (855) 670-1791

Purpose: ◯ Transfer of care ◯ Continuation of care
◯ Other: _____

By initialing below, I specifically authorize the release of the following to Cow Creek Health and Wellness Center:

_____ **Entire Record** (does not include sensitive information not marked below)
OR only the following (please check):
◯ 2 years from the last date of service: _____
◯ 5 years from the last date of service: _____
◯ Only the period of events from _____ to _____
◯ Other (specify Billing, Labs, Imaging, etc.): _____

Initials Required ***(If you would like any of the following sensitive information disclosed)***

_____ Alcohol/Drug Abuse Treatment/Referral
_____ HIV/AIDS-Related Treatment
_____ Sexually-Transmitted Infections or Diseases
_____ Reproductive Care
_____ Psychotherapy Notes ONLY (By initialing this line, I am waiving any psychotherapist-patient privilege)
_____ Mental Health (Other than psychotherapy notes)

Please indicate how much and what kind of SUD information you are authorizing to be disclosed:

_____ By initialing here, I specifically consent to the release of all of my SUD diagnosis, prognosis, treatment, and referral information.

_____ By initialling here, I wish to limit the release and disclosure of my SUD diagnosis, prognosis, treatment, and referral information to the following:

Expiration and Revocation

This authorization will expire (complete one):

- On date: _____
- On occurrence of the following event:

If no expiration date, event, or condition is listed, this consent form will expire **one year** from the date it is signed.

I understand that I may revoke this authorization IN WRITING at any time. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization was obtained as a condition of obtaining insurance coverage.

I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

Printed name of patient or patient's legal representative **Relationship to patient**

Signature of patient or legal representative **Date**

Patient Rights and Responsibilities

Purpose:

Cow Creek Health & Wellness Center's (CCH&WC) "Patient's Rights & Responsibilities" document reflects the legal rights you have as a patient, as well as your responsibilities and participation in your services and care. As a patient centered medical home in Oregon, we commit to empowering you and informing you. Here's what you need to know at the start of our care relationship.

Clinic Hours and Access

Our hours of business are Monday through Friday from 7:30 AM to 5:00 PM. During business hours we can be reached at (541) 672-8533 (North Clinic), or (541) 839-1345 (South Clinic). Our after-hours nursing line can be reached by calling the main numbers for either clinic.

Voicemails left with our reception staff will be returned within 24 hours. Questions for your provider will be returned within 48 hours or may require a visit with your provider. We request that you call the pharmacy 72 hours before your prescription is due for our team to process the refill.

If you need a language translator, large print, or information in another format, call us at 541-839-1345 and our care team will gladly assist.

Expectations for Patients, Families, and Caregivers

- Please arrive on time for your appointments and bring with you an up-to-date medication list or bring your medications with you to each and every appointment.
- Participate actively in your medical decision making and make us aware of any updates to your health status. If you have questions, please ask us!
- Indicate to your care team who you would like to have access to your healthcare information and have them sign a release of information.
- Respect clinic procedures, staff and other patients.
- Let us know of any demographic changes including changes to your: home address, telephone number, cell phone number and emergency contacts.

Clinic Policies and Procedures

Cancellations: Please notify our team 24 hours prior to any appointment cancellations. When calling to cancel an appointment our team will try to accommodate you with a telehealth appointment when appropriate.

Late Arrivals: A patient arriving up to 10 minutes late may have an abbreviated appointment or be requested to be rescheduled. If you are going to be late, please call our office ahead of time.

No Shows: If a patient doesn't show for an appointment they will be called to reschedule, and a letter will be sent out and this will be documented in the patient's chart. After a second no-show a letter will be sent out requesting the patient work with our care management team to identify barriers and to ensure they understand the seriousness of no-show appointments. A third no-show by a patient may impact the patient with scheduling restrictions.

Update Insurance: Provide us with an updated insurance card at the time of your visit.

Payment: Ensure your financial obligations are met and if you need to set up a payment plan, coordinate this with our team. Don't hesitate to ask us about our sliding fee scale.

No Weapons: We are a weapon-free campus, please do not bring any form of weapon into the clinic or on your person at any time.

Patient Rights and Responsibilities, Continued

Health Care Team Roles

Your care team consists of a primary care provider, nursing staff, laboratory staff, behavioral health providers, medical assistants and auxiliary staff who collaborate as a team to meet your care needs.

Your primary care provider manages both your chronic and acute care needs. They order laboratory tests and schedule specialty consults when indicated. These can include behavioral health appointments, appointments with our dietetic team and much more.

Our nursing staff ensures the quality of your health by assisting with triage and acute care needs as well as providing education on disease processes, medications, wound care, and other homecare routines.

Our medical assistants make sure you are up to date on your vaccines and screenings, ensure your questions are answered by the provider expediently, and prepare your medications for refills by the provider. Our medical assistants also coordinate with our support staff for status updates on referrals and prior authorizations.

Patient Rights: You have the right to:

- Participate in your healthcare decisions.
- Have informed consent for their care. Including informed consent to medical, mental health, substance use treatment and to refuse treatment as an adult or for a minor that has not reached legal age of consent. We follow consent policies that track the Oregon consent laws for medical and dental (ORS 109-640) mental health, drug or alcohol treatment (ORS 109-675) family planning, sexual or reproductive health (ORS 109-640) A detailed review of the Oregon laws can be found at: Understanding minor consent and confidentiality in health care in Oregon.
- Have confidentiality of your medical records.
- To receive care with dignity and respect without discrimination.
- Receive feedback on any grievance or complaint in a timely manner.
- To never face reprisal for making a complaint or voicing a grievance.
- Have your confidentiality protected by applicable Federal HIPAA policy and guidelines.
- Transfer your care upon request. Releasing your information to your new provider upon the signing of the release of information.
- Inspect your medical record in accordance with applicable rules that track Oregon law (ORS 179.505).
- The right to consent to your medical record disclosures in whole or part.
- Receive detailed information about services rendered and charges for care.
- Have access to care based upon CCH&WC service abilities and eligibility standards.
- Be informed of suicide risk and receive counseling and safety planning with your care team should the need arise.
- Consent for treatment along with a service and support plan will be updated and agreed to with the patient and/or their caregiver, parent or guardian.
- To be notified of transfers of care unless by doing so would pose a threat to your health and safety.
- CCH&WC does not use seclusion and restraint for any patients or clients they serve.
- Patients' rights and responsibilities are posted within our clinics, and you may request a copy at any time.

Patient Rights and Responsibilities, Continued

Complaints and Grievance Process

You may file a complaint or grievance at any time electronically, verbally, by phone or by mail. Grievances and complaints are processed by our Health Operations Administrator and reviewed by our leadership team. You will receive a response from the Health Operations Administrator within 72 business hours of filing a complaint that the complaint has been received and notified in writing of a resolution within 30 days of the complaint. You will never be penalized or retaliated against due to filing a complaint.

Financial Responsibility Acknowledgement

I acknowledge that I am financially responsible for all charges incurred for services provided by Cow Creek Health and Wellness Center (CCHWC) including those not covered by my insurance, Medicare, or any third-party payor. I understand that co-pays, deductibles, and any non-covered services are my responsibility and are due at the time of service unless otherwise arranged.

If it becomes necessary to pursue collections for any unpaid balance, I agree to pay all costs associated with collection efforts, including but not limited to collection agency fees, court costs, and reasonable attorney fees.

I authorize CCHWC to release information necessary to process my claims and secure payment form insurance companies, Medicare, or other responsible third parties. I acknowledge that CCHWC is governed by, and construed in accordance with, the laws of the Cow Creek Band of Umpqua Tribe of Indians ("Tribe") regardless of the laws that might otherwise govern under applicable principles of conflicts of laws thereof. I understand and agree that services provided by CCHWC establishes a consensual relationship between the parties for purposes of the Tribe's Tribal Court (the "Tribal Court") jurisdiction. I agree that the Tribal Court shall authority to resolve any dispute arising out of or relating to services provided by CCHWC. Services provided by CCHWC in no way waive or shall be interpreted as waiving the sovereign immunity of CCHWC, the Tribe or any party or third party. Providing services shall in no way expose or be interpreted as exposing CCHWC to the regulatory authority of any other tribal or state government, and references to local, state and/or federal laws and regulations as standards governing CCHWC's work shall in no way, and for no purpose, be interpreted as a waiver of CCHWC's or the Tribe's sovereign immunity.

CCHWC does not keep cash on hand to make change. Cash will still be accepted, but not to make change. If cash is your only option, overpayment will be accepted and applied to future balances on your account.

By signing below, I acknowledge the receipt of the Patient Rights and Responsibility Policy and agree to the terms and conditions set forth by said policy.

Printed name of patient or patient's legal representative _____ **Relationship to patient** _____

Signature of patient or legal representative _____ **Date** _____

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Name: _____ **Date:** _____ **Date of Birth:** _____

Reason for this Visit: _____ **Date of last physical exam:** _____

Past/Current Medical Conditions:

- ☐ Abdominal pain (moderate)
- ☐ Abnormal weight loss
- ☐ Alcohol dependence (alcoholism)
- ☐ Alzheimer's disease
- ☐ Amputation
- ☐ Anemia
- ☐ Anorexia or Bulimia
- ☐ Athritis
- ☐ Asthma
- ☐ Blood transfusion
- ☐ Cancer active or history
- ☐ Cardiac devices
- ☐ Cardiac failure
- ☐ Chemotherapy
- ☐ Complete colonoscopy
- ☐ Congenital heart disease
- ☐ Diabetes Mellitus
- ☐ Disorder of nasal sinuses
- ☐ Eczema
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hernia (Type: _____)
- ☐ Herpes Simplex Genital
- ☐ High colesterol
- ☐ HIV infection
- ☐ Hypertension
- ☐ Liver, stomach, or bowel disease
- ☐ Moderate headaches or migraines (frequent)
- ☐ Osteoporosis
- ☐ Palpitations
- ☐ Previous stent placement
- ☐ Renal/kidney dialysis
- ☐ Renal/kidney disorders
- ☐ Reported previous heart murmur
- ☐ Reported previous STD
- ☐ Rheumatism
- ☐ Stroke syndrome
- ☐ Thyroid disorders
- ☐ Tuberculosis
- ☐ Urinary tract infections
- ☐ Unspecified drug dependencies
- ☐ Other/not listed:

_____

Surgeries or Procedures

- ☐ Appendectomy (appendix removal)
- ☐ Back surgery
- ☐ Bone fracture repair
- ☐ Breast surgery or biopsy
- ☐ Cardiac surgery
- ☐ Carpal tunnel syndrome
- ☐ Cesarean section
- ☐ Cholecystectomy (gall bladder removal)
- ☐ Colostomy
- ☐ Cystoscopy
- ☐ Dilation & curettage
- ☐ Gastric bypass/sleeve
- ☐ Heart valve replacement
- ☐ Hemorrhoidectomy
- ☐ Hernia repair (if yes, type?)

_____

- ☐ Hip replacement
- ☐ History of intestinal polyp
- ☐ Hysterectomy
- ☐ Ileostomy
- ☐ Joint replacement
- ☐ Knee arthroplasty
- ☐ Lung surgery
- ☐ Mitral valve replacement
- ☐ Nephrectomy
- ☐ Neurological surgery
- ☐ Open fracture reduction
- ☐ Pancreatectomy
- ☐ Prostatectomy
- ☐ Prostate resection
- ☐ Removal of intestinal tumor
- ☐ Renal lithotripsy
- ☐ Renal transplant
- ☐ Repair of abdominal wall
- ☐ Shoulder surgery
- ☐ Small bowel resection
- ☐ Splenectomy
- ☐ Surgery for abdominal aortic aneurysm
- ☐ Surgery for diverticula
- ☐ Thyroid surgery
- ☐ Tonsillectomy
- ☐ Total hip replacement
- ☐ Tubal ligation
- ☐ Ulcer surgery
- ☐ Vasectomy
- ☐ Varicose vein ligation
- ☐ Wrist Surgery
- ☐ Other/Not Listed: _____

Family History

☐ Heart attack	☐ Gastric ulcer	☐ Stroke
☐ Alzheimer disease	☐ Hepatitis	☐ Thrombophlebitis
☐ Anxiety	☐ HIV infection	☐ Tuberculosis
☐ Asthma	☐ Hypertension	☐ None of above
☐ Autistic disorder	☐ Migraine headaches	☐ Other/not listed: Use spaces below
☐ Congestive heart failure	☐ Nephrolithiasis	☐ Cancer (please specify type below)
☐ Diabetes	☐ Osteoarthritis	
☐ Eczema	☐ Seizure disorder	
☐ Esophageal reflux	☐ Sickle cell anemia	

If you answered yes above, please note which relative(s) has/had the history:

- ☐ Mother:
- ☐ Father:
- ☐ Brother:
- ☐ Sister:
- ☐ Grandma (paternal or maternal):
- ☐ Grandpa (paternal or maternal):

Medications

Name	Dosage	AM/PM	Frequency

Allergies

Name	Reaction

Social History

Smoking: ☐ Yes ☐ No Packs per day: _____ Other tobacco products: _____ Vape products: _____	Education:
Alcohol: ☐ Yes ☐ No Frequency: _____	Employment status:
Caffeine: ☐ Yes ☐ No Frequency: _____	Marital status (check one) ☐ M ☐ S ☐ D ☐ W

Recreational Drug Use

- ☐ Amphetamines
- ☐ Barbituates
- ☐ Cocaine
- ☐ Ecstasy
- ☐ Hallucinogens
- ☐ Heroin
- ☐ Marijuana
- ☐ Methamphetamines
- ☐ PCP
- ☐ No recreational drug use
- ☐ Other(s): _____

_____

- ☐ Frequency of use:_____

_____

Email Communication Authorization and Acknowledgement Form, Page 1

If you are submitting the New Patient Registration Packet or Annual Patient Update Form by email to patientintake@cowcreek-nsn.gov, this form must be submitted along with them for processing.

If you are not submitting your forms by email, you do not need to fill out this form.

Once intake is complete, a receptionist will contact you to schedule your new patient appointment.

Patient's Name:_____ **Date:** _____

Patient's Email Address:_____

By signing this form, I authorize Cow Creek Health & Wellness Center (CCH&WC) to receive my completed patient packet (registration and administrative forms that may contain protected health information [PHI]) via email for patient registration and administrative purposes only.

I understand that:

- Email communication is patient-initiated and not a secure method of transmitting PHI.
- CCH&WC offers more secure communication options, including the patient portal.
- CCH&WC will not send or respond with PHI via email.
- Any follow-up communication will occur by phone or in person.
- If you require immediate assistance or have serious or worsening condition, you should not rely on email. Instead, you should call CCH&WC for an appointment or take other measures as appropriate.

Acknowledgement of Email Risks:

- I understand and acknowledge the following risks associated with the electronic transfer of my health information via email communication:
- Email communication may not be secure, and there is a risk that my health information could be intercepted, accessed, or disclosed by unauthorized individuals. CCH&WC and its staff are not responsible for any unauthorized disclosure of my health information.
- Emails may be delivered to the wrong recipient if an incorrect email address is used.
- Standard email is not encrypted and may be intercepted during transmission.
- Emails may be stored on servers outside the control of CCH&WC.
- Once sent, CCH&WC cannot guarantee the privacy or security of the email.
- Even after the deletion of an email, back-up copies may exist on a computer.

Email Communication Authorization and Acknowledgement Form, Page 2

By signing this form, I authorize Cow Creek Health & Wellness Center (CCH&WC) to receive my completed patient packet (registration and administrative forms that may contain protected health information [PHI]) via email for patient registration and administrative purposes only.

Patient Acknowledgement: (Please initial next to each item below)

_____I understand the risks of using email and choose to proceed.

_____I understand this authorization applies only to emails I send to CCH&WC.

_____I understand I may revoke this authorization at any time by submitting a written request.

_____I understand CCH&WC encourages encryption of any email containing PHI.

_____I will notify CCH&WC immediately of any changes to my email address.

_____I will NOT use email for urgent or time-sensitive matters and will call CCH&WC instead.

_____I agree to hold CCH&WC harmless for any unauthorized use, disclosure, or access of my protected health information that may occur during, or as a result of, electronic transmission.

Duration of Authorization

This authorization remains in effect until revoked in writing. Revocation does not apply to information already received by CCH&WC prior to the revocation.

By signing below, I acknowledge that I have read and understand this authorization and the associated risks. I voluntarily consent to the disclosure of my health information as described above.

Printed name of patient or patient's legal representative _____ **Relationship to patient** _____

Signature of patient or legal representative _____ **Date** _____