Camai
Community Health Center

CONSENT FOR TREATMENT AND BILLING PRACTICES

Printed Patient Name: _____ Patient Date of Birth: _____

Informed Consent for Treatment
I consent (agree) to health care including routine diagnostic procedures, medical treatment and other health services provided by Camai Community Health Center and its authorized personnel and agents.
I understand that:

- The practice of medicine is not an exact science and that diagnosis and treatment involve risks of injury and sometimes death. I acknowledge there is no guarantee about the results of the examinations, treatment or health services provided by Camai.
- Except in emergency or extra ordinary circumstances, no substantial procedures are performed upon a patient unless, and until, he/she has had an opportunity to discuss them with a physician or other health professional to the patient's satisfaction.
- Each patient has the right to consent or refuse to any proposed procedure or treatment plan.
- No patient will be involved in any research or experimental procedure without his/her full knowledge and consent.

_____ Patient/Guardian Initials

Notice of Privacy Practices
I acknowledge and agree that I have reviewed a copy of Camai's Notice of Privacy Practices made available to me. I acknowledge that I may request a copy of the notice at any time.

_____ Patient/Guardian Initials

Statement for Release of Information for Audit Purposes
The process of checking business records and policies is called an audit. Auditors are officials that check patient financial applications to make sure Camai is following grant rules. Auditors will only use your information to ensure that Camai is processing applications and payments correctly.

- I consent to the release of any of my financial records that may be considered necessary for review by any auditor for any assistance program that I am eligible for, or participating in.
- Audited programs may include but are not limited to sliding fee scale and grant-assisted programs.
- Financial records that may be deemed necessary for review include but are not limited to: sliding fee scale application and supporting documents, patient information, insurance information, and any other types of information contained within my electronic medical records.

_____ Patient/Guardian Initials

Please complete both sides of this form

Release, Assignment, and Statement of Responsibility
I authorize (give permission for) the release of any information necessary to process my insurance claims and assign and request payment directly to Camai Community Health Center. I understand that I may revoke (withdraw) this consent at any time in writing to this office.

I understand that:

- I am responsible for payment for all services and products provided to me, or any patient for which I am the guarantor of payment.
- I agree, whether I sign as legal guardian, guarantor, or patient to pay that account in accordance with the regular rates and terms of Camai.
- If the account is referred to an attorney or collection agency for collection, I will pay actual attorney's fees and the collection expense. If your account is 30 days past due, you may be charged interest at the legal rate.

_____ Patient/Guardian Initials

Patient Notice of Billing Practice and Office Policy
Payment for services provided by Camai is due at the time of service. We accept: cash, Visa, MasterCard, debit cards and personal checks. Payment plan options are reviewed individually.

Health Insurance: If you have health insurance, we will send the bill to your insurance company for you.

- If you are not sure if your provider is in-network or preferred with your insurance plan, please ask us before your appointment.
- We expect you to pay at the time of service for any estimated patient responsibility portion, including co-pays, deductibles, coinsurance, and/or charges for non-covered services.
- We allow a 90-day grace period for your insurance to respond to our claims. If the insurance company does not respond to our claims within 90 days, you will be responsible for paying the full balance.

Sliding Fee Discount Program: Camai is non-profit community health center. We have a sliding fee discount for patients whose household income is below 200% of Alaska's Federal Poverty Level. This discount is available to qualified uninsured and under-insured patients.

- The Sliding Fee Discount can be used for co-pays, deductibles and co-insurance.
- If your income or household size changes, you must update your sliding fee application.
- You must update your application annually to qualify for the sliding fee discount.

_____ Patient/Guardian Initials

I have read the statements above. I understand my rights as a patient and financial responsibility to Camai Community Health Center. If I have additional questions, I will speak to a staff member before my appointment.

Patient Signature: _____ Date:_____

Printed Parent/Guardian Name: _____

Parent/Guardian Signature: _____
(if patient is under the age of 18 a parent/guardian signature is required)

Please complete both sides of this form

Camai
Community Health Center

HIPAA Privacy Authorization Form

I understand that Camai Community Health Center may still use and disclose protected health information as indicated in the Notice of Privacy Practices. Would you like to give someone else access to your medical records?

_____ Yes _____ No

If you answered Yes, please provide the following information on who you would like to grant access:

Full Name (please print)	Relationship to Patient	Phone	Authorized to Disclose:	
			Medical	Financial

This Authorization is being granted at the request of the patient. Unless otherwise revoked, this Authorization expires 12 months after the date of signing this form.

I understand that I have the right to revoke this Authorization at any time by sending a written notification to the address listed at the bottom of this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that I have the right to refuse to sign this Authorization and that my treatment will not be conditioned on signing.

I understand that information used or disclosed as a result of this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Patient Name (print): _____ Date of Birth: _____

Signature: _____ Date: _____

Parent/Guardian Signature: _____
(required if patient is under 18)

Send any correspondence to:
Camai Community Health Center, PO Box 211, Naknek, AK 99633

Camai
Community Health Center

CONSENT FOR PATIENT RECORD SHARING AND MEDICATION HISTORY AUTHORIZATION

Patient Name: _____

Patient Date of Birth: _____

Consent to Share Medical Records
I consent to allow Camai to share and receive my medical records with providers at connected care locations.

_____ Patient/Guardian Initials

Consent to Access Medication History
I consent to allow Camai to download my medication history automatically from pharmacy benefit managers.

_____ Patient/Guardian Initials

I have read the statements above. I understand my rights as a patient and financial responsibility to Camai Community Health Center. If I have additional questions, I will speak to a staff member before my appointment.

Patient Signature: _____

Date: _____

Printed Parent/Guardian Name:

_____

Parent/Guardian Signature:

_____

(if patient is under the age of 18 a parent/guardian signature is required)

Camai
Community Health Center

CAMAI COMMUNITY HEALTH CENTER
AUTHORIZATION FOR TREATMENT OF CHILD

Name of Child: _____

Child's Birth Date: _____ Current Date: _____

Name of Consenting
Parent/Legal Guardian: _____

Parent of legal guardian consent must be provided for treatment of a child (minor patient under the age of 18). We understand there are times that it may not be possible for you to accompany your child to each visit and it may be more convenient to have prior authorization for delivery of medical treatment directly to a child without the parent tor legal guardian being present. Therefore, the providers in this office will accept the below authorization to treat your child for any visit. If you wish to authorize treatment to your child when another adult brings your child in, this authorization must specify the name(s) of the adult(s) over the age of 18 who are authorized to bring your child in for treatment.

Special Note about Preventive Care Visits and Immunizations
Preventive visits are an opportunity to provide education on your child's growth and development as well as directly address your concerns. Important details about your child may not be available from caregivers, adult siblings or grandparents. During these preventive care visits, important vaccinations may be administered. It is vitally important you understand the risks and benefit of each vaccine by reviewing a vaccine information sheet for each vaccine given. **We would PREFER that the parent or legal guarding be present for preventive care visits.** However, if this is not possible, this authorization for treatment may be used as well, for preventive care visits and administration of vaccines.

AUTHORIZATION TO ALLOW OR NOT ALLOW PROVIDERS TO TREAT CHILD WHEN TO ACCOMPANIED BY ANY ADULT
(You MUST check one of the boxes below)

☐ By checking this box, I DO authorize treatment of my child when my child is not accompanied to the office by me or any of the adult(s) listed below. The providers may give any such treatment the provers determine is appropriate for my child, including but not limited to preventive care visit, physical exam, re-check, sick visit, diagnostic examination, immunizations and injections, x-rays, lab tests, and any prescription of any medication deemed necessary at that time.

☐ By checking this box, I DO NOT authorize treatment of my child unless accompanied to the office by me or any of the adults listed below:

Name of Child: _____

Child's Birth Date: _____

Name of Consenting
Parent/Legal Guardian: _____

AUTHORIZATION TO ALLOW PROVIDERS TO TREAT CHILD WHEN ACCOMPANIED BY BELOW LISTED ADULTS

(Complete this section only if you want another adult to be able to bring your child in for treatment)

I give Camai Community Health Center authorization to treat my child for any such treatment the providers determine is appropriate for my child, including but not limited to preventive care, physical exam, re-check, sick visit, diagnostic examination, immunizations and injections, x-rays, lab tests, and any prescription of any medication deemed necessary when brought to the office by the following adult(s):

_____ _____
(Print name of adult) (Print relationship to child)

_____ _____
(Print name of adult) (Print relationship to child)

_____ _____
(Print name of adult) (Print relationship to child)

Since the adult(s) named above are involved in my child's health care, I further authorize that the providers can give and discuss with the adult(s) protected health information (PHI) about my child and understand that the adult(s) listed above will be responsible for conveying any such PHI given by or discussed with the providers to me.

REVOCATION OF AUTHORIZATION

I agree that if at any time, I no longer want the providers to communicate with the adult(s) named above, or no longer want this authorization to be effective, I will immediately notify Camai Community Health Center in writing by sending a letter to PO Box 211, Naknek, AK 99633. The revocation will be effective no later than 5 business days after receipt to allow time for processing. The revocation will be deemed a revocation of this authorization in its entirety. I understand that if I want to allow for any future authorization for treatment of my child I will have to complete and sign a new authorization form.

This authorization is in effect for a period of one year from the date signed below unless revoked sooner.

_____ _____
(Signature of Parent/Legal Guardian) (Date)

Camai Community Health Center

2 School Road (physical address)
PO Box 211 (mailing address)
Naknek, AK 99633
907-246-6155 | camaichc.org

PATIENT REGISTRATION

Today's date: _____

Required Patient Information		
First Name:	Middle Name:	Last Name:
Assigned Sex at birth: M F	Date of Birth:	Social Security Number:
Mailing Address (PO Box **required** if you do not have home delivery of mail):		
Phone Numbers: ☐ Cell: _____ ☐ Home: _____ ☐ Work: _____	Email Address: **Consent to text? ☐ Yes ☐ No**	

We are required by our federal funding to ask the questions below. If you do not want to answer, please check "CHOSE NOT TO DISCLOSE"

Is English your primary language? ☐ Yes ☐ No If no, what is?_____
If no, do you require a translator? ☐ Yes ☐ No

Ethnicity:	Race:
☐ Latino/Hispanic	☐ Caucasian/White ☐ Asian ☐ Pacific Islander
☐ Not Latino/Hispanic	☐ Black/African American ☐ Native Hawaiian ☐ Other
☐ **CHOSE NOT TO DISCLOSE**	☐ American Indian/Alaska Native ☐ **CHOSE NOT TO DISCLOSE**

Marital Status:	Sexual Orientation:
☐ Single ☐ Married ☐ Divorced	☐ Straight (not lesbian or gay) ☐ Something else
☐ Separated ☐ Other	☐ Lesbian or Gay ☐ Bisexual ☐ Don't know
	☐ **CHOSE NOT TO DISCLOSE**

Gender Identity:	# of people in household (adults + children)	Yearly household Income
☐ Male ☐ Female ☐ Other		$ _____
☐ Transgender Male		☐ **CHOSE NOT TO DISCLOSE**
☐ Transgender Female		
☐ **CHOSE NOT TO DISCLOSE**		

Please mark all that apply: ☐ Veteran ☐ Homeless ☐ Public Housing ☐ Agricultural Worker
☐ **CHOSE NOT TO DISCLOSE**

~PLEASE COMPLETE OTHER SIDE~

Emergency Contact Information

Name of next of Kin: _____ Phone: _____

Relationship to patient: _____

Emergency Contact Name: _____ Phone: _____

Relationship to patient: ☐ Wife ☐ Husband ☐ Parent ☐ Grandparent ☐ Other

Guarantor Information

(Person paying for account charges; fill out if person paying for care is not the patient)

Legal First Name:	Middle Initial:	Last Name:
City:	State:	Zip:
Guarantor Date of Birth:	Social Security Number:	Phone Number:

Patient relationship to guarantor:

☐ Wife ☐ Husband ☐ Parent ☐ Grandparent ☐ Life Partner ☐ Other

Primary Insurance Information

Subscriber Name (name on insurance card):	Subscriber Social Security Number:
Subscriber Date of Birth:	Subscriber ID Number:
Plan Carrier (Insurance Company):	
Group ID:	Claims Address:

Secondary Insurance Information (if applicable)

Subscriber Name (Name on insurance card):	
Subscriber Date of Birth:	Subscriber ID Number:
Plan Carrier (Insurance Company):	
Group ID:	Claims Address:

CAMAI COMMUNITY HEALTH CENTER
Pediatric Health History Ages Birth-11yrs

Name:_____ DOB:___/___/___ Date of Visit: ___/___/___

Reason for visit:

Patient Preferences

Date of last physical: ___/___/___
Preferred pharmacy: _____
Preferred Lab: _____
Other Providers you see: _____

Allergies

List and describe reaction: medicine, food, environmental

Current Medications

Including inhalers, herbs, supplements, and over-the-counter

Medication Name	Dose (mg,ml)	Frequency (how often)?

Vaccines

Patient has been vaccinated □ Yes □ No	Do you have immunization records? □ Yes □ No
Please list where patient has received vaccines:	

Family History

Family Medical History	Relationship to you				
Breast Cancer	☐Father	☐Mother	☐Sibling	☐Child	☐Other:
Colon Cancer	☐Father	☐Mother	☐Sibling	☐Child	☐Other:
Other Cancer	☐Father	☐Mother	☐Sibling	☐Child	☐Other:
Heart attack/ Disease	☐Father	☐Mother	☐Sibling	☐Child	☐Other:
High cholesterol	☐Father	☐Mother	☐Sibling	☐Child	☐Other:
High Blood Pressure	☐Father	☐Mother	☐Sibling	☐Child	☐Other:
Diabetes	☐Father	☐Mother	☐Sibling	☐Child	☐Other:
Osteroporosis	☐Father	☐Mother	☐Sibling	☐Child	☐Other:
Bleeding disorder	☐Father	☐Mother	☐Sibling	☐Child	☐Other:
Stroke	☐Father	☐Mother	☐Sibling	☐Child	☐Other:
Depression	☐Father	☐Mother	☐Sibling	☐Child	☐Other:
Alcoholism	☐Father	☐Mother	☐Sibling	☐Child	☐Other:
Suicide	☐Father	☐Mother	☐Sibling	☐Child	☐Other:
Death before age 50	☐Father	☐Mother	☐Sibling	☐Child	☐Other:
Other: _____	☐Father	☐Mother	☐Sibling	☐Child	☐Other:

CAMAI COMMUNITY HEALTH CENTER
Pediatric Health History Ages Birth-11yrs

Social History
Check any that apply

Diet: □ Regular □ Vegetarian □ Vegan □ Gluten Free □ Specific □ Carbohydrate □ Cardiac □ Diabetic

Caffeine Intake: □ None □ Occasional □ Moderate □ Heavy

Exercise: □ None □ Occasional □ Moderate □ Heavy

Sporting Activities:

Parents marital status: □ Unknown □ Married □ Single □ Divorced □ Separated □ Widowed □ Domestic Partner

Home situation: □ Both parents □ Mother □ Father □Relatives □ Adoptive parents □ Foster parents
Other:

Siblings (include ages):

Childcare: □ None □ Relative □ Private Sitter □ Daycare/preschool

Animal exposure: □ Yes □ No	**Passive smoke exposure:** □ Yes □ No	**Smoke/CO detector, home:** □ Yes □ No
Seat belt/car seat used: □ Yes □ No	**Guns present in home:** □ Yes □ No	**Year in school:**
Bike helmets: □ Yes □ No	**Bullying:** □ Yes □ No	**School Name:**

Have you seen a dentist in the past 12 months? □ Yes □ No

Surgical History

Surgical Procedure	Date & performing provider

Past Medical History
Please CIRCLE if you have ever had any of the following:

Abuse/ Violence	Bladder/kidney issues	Eczema	MRSA exposure
Acid Reflux (GERD)	Blood transfusion	GI problems	Muscle, joint, or bone problems
Acne	Cancer	Head injury/concussion	Obesity
AIDS/HIV	Chicken pox	Headaches/Migraines	Seizures/epilepsy
Allergies	Constipation	Heart Problems	Skin problems
Anemia	Depression	Hepatitis	Thyroid problems
Anxiety Disorder	Developmental/behavior disorders	Hospital admission other than birth	Tuberculosis
Asthma	Diabetes	Hypertension	Vision or eye problems
Birth defect/disease	Ear/hearing problems	Liver disease	Other:
Blood disease	Eating disorder	Lung disease	Other:

Birth History
Complete for children aged **2 and under** by circling pertinent history

Birth Hospital:	Birth Weight:

Breathing problems	Intubation	Preterm labor
C-section	Jaundice	Scalp bruise
Fetal distress	Maternal infections	Vacuum
Hearing screen completed	NICU admit	Vaginal deliver
Infection at birth	Premature rupture of membranes	VBAC

CAMAI COMMUNITY HEALTH CENTER
Pediatric Health History Ages Birth-11yrs

Review of Systems Please check if you experince any of the following:							
General Symptoms		Arm pain on exertion		Increased urinary freq		**Psychiatric**	
	Fever		Shortness of breath walking		Blood in urine		Depression
	Night sweats		Shortness of breath laying		Incomplete emptying		Sleep distrubances
	Unexplained weight loss/gain		Palpitations		**Musculoskeletal**		Restless sleep
	Exercise intolerance		Known heart murmur		Muscle aches		Unsafe relationship
Eyes			Light-head on standing		Muscle weakness		Alcohol abule
	Dry eyes	**Respiratory**			Back pain	**Endocrine**	
	Irritation		Cough		Swelling in extremeties		Fatigue
	Vision change		Wheezing	**Integumentary**			Increased thrist
ENMT			Shortness of breath		Abnormal mole		Hair loss
	Difficulty hearing		Coughing up blood		Jaundice		Increased hair growth
	Ear pain		Sleep apnea		Rash		Cold intolerance
	Frequent nosebleeds	**Gastrointestinal**			Itching	**Hematologic/lymph**	
	Nose/sinus problems		Abdominal pain		Dry skin		Swllen glands
	Sore throat		Vomiting		Growth/lesion		Easy bruising
	Bleeding gums		Change in appetite		Laceration		Excessive bleeding
	snoring		Black/tarry stool	**Neurologic**		**Allergic/immunologic**	
	Dry mouth		Frequent diarrhea		Loss of consciousness		Runny nose
	Oral abnormality		Vomiting blood		Weakness		Sinus pressure
	Mouth ulcer		Indigesting (dyspepsia)		Seizures		Itching
	Teeth abnormality		GERD		Dizziness		Hives
	Mouth breathing	**Genitourinary**			Frequent headaches		Frequent sneezing
Cardiovascular			Urinary loss of control		Migraines		
	Chest pain on exertion		Difficulty urinating		Restless legs		

Patient Name: _____ DOB:_____