ARIA COMMUNITY HEALTH CENTER
ACHC

New Patient Packet: English
Paquete para Nuevos Pacientes: Inglés

PATIENT INFORMATION / *INFORMACIÓN DEL PACIENTE*

Last Name / *Apellido*	First Name / *Primer nombre*	Middle Name / *Segundo nombre*	Maiden Name / *Apellido de soltero (a)*
Birthdate / *Fecha de nacimiento*	Gender / *Género*	Social Security No. / *Seguro social*	Marital Status / *Estado civil*
Street Address / *Dirección del domicilio*	Apt # / *# de Apartamento*	Mailing Address / *Dirección de correo*	
City / *Ciudad*	State / *Estado*	Zip Code / *Código postal*	Cell Phone # / *Número de Celular*
Occupation / *Ocupación*	Employer Name / *Nombre del empleador*	Employer Address / *Domicilio de empleo*	Phone No. / *Teléfono*
Email/ *Correo electrónico*			

GUARANTOR INFORMATION (Person responsible for payment) / *INFORMACIÓN DE PERSONA RESPONSABLE POR PAGO*

Last Name / *Apellido*	First Name / *Primer nombre*	Middle Name / *Segundo nombre*	Maiden Name / *Apellido de soltero (a)*
Birthdate / *Fecha de nacimiento*	Gender / *Género*	Social Security No. / *Seguro social*	Marital Status / *Estado civil*
Street Address / *Dirección del domicilio*	Apt # / *# de Apartamento*	Mailing Address / *Dirección de correo*	
City / *Ciudad*	State / *Estado*	Zip Code / *Código postal*	Cell Phone # / *Número de Celular*
Occupation / *Ocupación*	Employer Name / *Nombre del empleador*	Employer Address / *Domicilio de empleo*	Phone No. / *Teléfono*

EMERGENCY INFORMATION / *INFORMACIÓN EN CASO DE EMERGENCIA*

Relationship to Patient / *Relación con el Paciente*	Last Name / *Apellido*	First Name / *Primer nombre*	Middle Initial / *Inicial del segundo nombre*
Street Address / *Dirección del domicilio*	City / *Ciudad*	State / *Estado*	Zip Code / Código postal
Home Phone or Cell / *Teléfono de Casa o Celular*	Work Phone / *Teléfono de empleo*		

INSURANCE INFORMATION (List all insurance plans you have) / *INFORMACIÓN DE ASEGURANZA (Anote todos planes de seguro que tenga)*

Name of Insurance Company #1 / *Nombre de Compañía de seguro*	Group No. / *Número de grupo*	Name of policy holder / *Nombre del titular de la póliza*	Social Security No. / *Número de seguro social*
Name of Insurance Company #2 / *Nombre de Compañía de seguro*	Group No. / *Número de grupo*	Name of policy holder / *Nombre del titular de la póliza*	Social Security No. / *Número de seguro social*
Name of Insurance Company #3 / *Nombre de Compañía de seguro*	Group No. / *Número de grupo*	Name of policy holder / *Nombre del titular de la póliza*	Social Security No. / *Número de seguro social*

See Next Page / *Vea la página siguiente*

This page was intentionally left blank

ARIA COMMUNITY HEALTH CENTER

CONDITIONS OF REGISTRATION:

1. CONSENT TO TREATMENT:

I, a patient of Aria Community Health Center, do hereby voluntarily consent to health care, encompassing diagnostic procedures, and medical/dental treatment by the Health Center staff. I am aware that the practice of medicine/dentistry/surgery is not an exact science. I acknowledge that no guarantee or assurance has been made to me concerning the results of my treatment. Additionally, if I elect to seek alternative care and/or refuse further evaluation, treatment, and/or transport I release Aria Community Health Center of any liability or medical claims resulting from my decision to refuse care against medical advice.

2. NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received a copy of the Notice of Privacy Practices (NPP), which describes when the health center may use or disclose my information for treatment, payment, and health care operations, my legal rights relating to this information and how I can file a complaint, if I believe my rights have been violated. The NPP is incorporated into these Conditions of Registration and Financial Agreement by this reference. This notice is only provided the first time I receive services from the health center and is otherwise available upon request.

3. MEDICARE ASSIGNMENT:

I certify that the information given by me in applying for payment under Tile XVIII of Social Security Act is correct. I request that payment of authorized benefits be made in my behalf.

4. ASSIGNMENT OF INSURANCE BENEFITS:

In the event I am entitled to outpatient benefits arising out of any policy of insurance insuring me of any party liable to me, I hereby assign said benefits directly Aria Community Health Center for application to my bill. I agree that Aria Community Health Center may issue receipt of any such payment, that such payment shall discharge the insurance company of any and all obligations under the policy to the extent of the payment, and that I shall be responsible for charges not covered by this assignment.

5. FINANCIAL AGREEMENT:

I hereby agree that in consideration for services to be rendered by Aria Community Health Center, I shall make prompt payments to the account Aria Community Health Center as bills are presented. I agree to pay interest at the legal rate should the account become delinquent, and if it becomes necessary for the account to be referred to collections, I shall pay any fees and collection expenses.

6. GUARANTOR:

I hereby agree to assume the obligations imposed by the "Financial Agreement" above.

7. TEACHING PROGRAM:

To the extent that Aria Community Health Center conducts teaching programs to which the patient's condition or treatment is pertinent, students shall be permitted to participate in the care of the patient unless Aria Community Health Center is notified to the contrary in writing.

8. HEALTH INFORMATION EXCHANGE:

California Health and Safety Code 130290 requires Aria Community Health Center to share health information about you with other health care providers or health care entities through electronic health information exchanges in which Aria participates. This electronic exchange of information means every participating health care provider can access the information they need to treat you quickly and safely.

9. CONTACT RELEASE:

Aria Community Health Center routinely contacts patients by phone, text, and email (if provided), and/or mail to send important health care messages such as appointment reminders and patient satisfaction surveys. Patients or their representatives who do not wish to be contacted by phone, text, or email, may opt out when the message is received.

10. OPEN PAYMENTS NOTICE:

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided below. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public. The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

Date	Signature of Patient / Parent / Guardian	Relationship to Patient (if applicable)	Witness (office staff)

See Next Page / *Vea la página siguiente*

This page was intentionally left blank

We are required by the federal government to ask you these questions, and while it will be helpful if you answer them, you are not required to do so to receive healthcare services.

Acct#

PERSONAL & HOUSING

Patient name: | **Today's Date:**

DOB: | **Age:** | **Gender at Birth:** ◯ Male ◯ Female

Patient Address: Street City State Zip Code

Phone # **Email:**

How many families live at this address: ◯ Just mine ◯ More than just mine: If so, how many Families _____ Persons _____

At this address, I am the: ◯ Owner ◯ Only Renter ◯ Primary Renter ◯ A sub renter ◯ Not paying rent

If shared, do you live in or share: ◯ A Room or ◯ A Garage or ◯ Another building at this address

Or I am Homeless: ◯ On the Street ◯ In A Homeless Shelter ◯ Transitional Housing

What language do you prefer speaking?
◯ English ◯ Spanish ◯ Sign Language ◯ Other: _____

What language do you prefer reading?
◯ English ◯ Spanish ◯ Other: _____

If appropriate, please indicate your current status with the United States Military: ◯ Active Duty ◯ Active Reserves ◯ National Guard ◯ Honorable Discharge ◯ General Discharge ◯ Other Discharge ◯ Retired ◯ Separated

ETHNICITY

◯ **Not Hispanic, Latino/a, or Spanish Origin.**

◯ **Hispanic, Latino/a, or Spanish Origin.** *If you selected, Hispanic, please select one of the below:*

◯ *Yes, Mexican, Mexican American, Chicano/a* ◯ *Yes, Puerto Rican* ◯ *Yes, Cuban* ◯ *Yes, Another Hispanic, Latino/a, or Spanish Origin*

◯ *Yes, Hispanic, Latino/a, Spanish Origin, Combined*

◯ **Decline to specify.**

RACE

In addition to your Ethnicity, please clarify what Race(s) you identify yourself as ***(you may check more than one):***

◯ Asian Indian ◯ Korean ◯ Other Pacific Islander ◯ American Indian/Alaska Native
◯ Chinese ◯ Vietnamese ◯ Guamanian or Chamorro ◯ White
◯ Filipino ◯ Other Asian ◯ Samoan ◯ Chose not to disclose race
◯ Japanese ◯ Native Hawaiian ◯ Black/African American

EMPLOYMENT & INCOME

A. How many people are in your family? _____

B. What is your family Income? _____ ◯ Week ◯ Month ◯ Year

C. Have you or any wage earner in your family:

◯ Yes ◯ No Worked as a **Farmworker** during the past 2 years
◯ Yes ◯ No Retired from **Farm work**, or
◯ Yes ◯ No Remain disabled from **Farm work**?

D. If all answers in "C" are No, Skip "E". If yes, what is the relationship of the farmworker to the patient?

◯ Self ◯ Spouse ◯ Parent ◯ Child ◯ Other _____

E. If in item "C" are yes, are you or they (mark all that apply):

◯ Migrant: During the past 2 years, you spent a night somewhere else to work?
◯ Seasonal: Stay in one place but off work for more than 2 weeks every year?
◯ Full Time: Never laid off from farm work for more than 2 weeks during the past 2 years?

Signature _____ Date _____

Printed Name _____ Relation to Patient _____

This page was intentionally left blank

This page was intentionally left blank

ARIA COMMUNITY HEALTH CENTER

ARIA COMMUNITY HEALTH CENTER PATIENT INFORMATION

Información del paciente de Aria Community Health Center

PERSONAL HEALTH HISTORY

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

Do you have or have you ever had any of the following:

SKIN	(NEVER)	(PAST)	(NOW)
Rashes, hives, itching or other skin irritations.	( )	( )	( )

EYES, EARS, NOSE, THROAT	(NEVER)	(PAST)	(NOW)
Headaches,dizziness,fainting	( )	( )	( )
Blurred or impaired vision	( )	( )	( )
Hearing loss or ringing in ears	( )	( )	( )
Discharge from eyes or ears	( )	( )	( )
Sinus trouble/colds/allergies	( )	( )	( )
Asthma or hay fever	( )	( )	( )
Sore throats/hoarseness	( )	( )	( )

CARDIOPULMONARY	(NEVER)	(PAST)	(NOW)
Shortness of breath	( )	( )	( )
Persistent cough or coughing up blood or other secretions	( )	( )	( )
Chills and/or fever	( )	( )	( )
Night sweats	( )	( )	( )
Tuberculosis or exposed to TB	( )	( )	( )
Scarlet fever or rheumatic fever	( )	( )	( )
Chest pain	( )	( )	( )
Heart palpitations or rapid heartbeat or pulse	( )	( )	( )
High blood pressure	( )	( )	( )
Swelling of hands and/or feet	( )	( )	( )

GASTROINTESTINAL	(NEVER)	(PAST)	(NOW)
Heartburn or indigestion	( )	( )	( )
Nausea and/or vomiting	( )	( )	( )
Loss of appetite	( )	( )	( )
Belching or gas	( )	( )	( )
Peptic ulcer, gallbladder, or liver disease	( )	( )	( )
Yellow juandice or hepatitis	( )	( )	( )
Diarrhea or constipation	( )	( )	( )
Dysentery	( )	( )	( )
Rectal bleeding, hemorrhoids (piles)	( )	( )	( )
Tarry or clay-colored stools	( )	( )	( )

GLANDS	(NEVER)	(PAST)	(NOW)
Weight gain or loss	( )	( )	( )
Diabetes	( )	( )	( )
Thyroid or goiter	( )	( )	( )
Swollen glands	( )	( )	( )

GENITOURINARY	(NEVER)	(PAST)	(NOW)
Kidney disease or stones or Bright's disease	( )	( )	( )
Painful, frequent, or urgent urination	( )	( )	( )

GENITOURINARY	(NEVER)	(PAST)	(NOW)
Blood or pus in urine	( )	( )	( )
Sexually transmitted disease (venereal disease)	( )	( )	( )
Been sexually active with anyone who has AIDS or HIV or hepatitis	( )	( )	( )

NEUROMUSCULAR	(NEVER)	(PAST)	(NOW)
Problems with becoming tired and/or upset easily	( )	( )	( )
Nervous breakdown/depression	( )	( )	( )
Poliomyelitis (infantile paralysis)	( )	( )	( )
Convulsions	( )	( )	( )
Joint and/or muscular pain	( )	( )	( )
Back pain or injury/osteomyelitis/rheumatism	( )	( )	( )
Are you currently taking any medications?	( )	( )	( )

If yes, please list them

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

Have you ever had or been treated for cancer or any tumors?	( )	( )	( )
Are you anemic or have you ever had to take iron medication?	( )	( )	( )
Do you use tobacco? *If yes, what type:* _____	( )	( )	( )
Do you use drugs or alcohol? If yes what?	( )	( )	( )
Drug	( )	( )	( )
Alcohol	( )	( )	( )

WOMEN ONLY

Last menstrual period:

Birth control:

List dates of all operations/surgeries, injuries and illnesses that required hospitalization:

1. 3.
2. 4.
5. 6.

Were you ever rejected from the military or for employment?	( )	( )	( )
Were you absent from school/work in the past 10 years because of illness or injury	( )	( )	( )
Did you ever file a worker's compensation claim?	( )	( )	( )
Did you ever seek psychological or psychiatric treatment?	( )	( )	( )
Do any of the above involve a worker's compensation claim of job injury?	( )	( )	( )

Authorization to Discuss Medical/Dental Information

I hereby authorize Aria Community Health Center (ACHC) to use or disclose the specific information described below, only for the purposes and parties also descried below.
Description of the specific information to be discussed:

- ☐ Appointment Date/Times
- ☐ Diagnosis
- ☐ X-Ray Results
- ☐ Medications
- ☐ Lab Tests/Results
- ☐ Summary of Medical Records
- ☐ Care plan
- ☐ Other (Specify): _____

Indicate Confidential Information:

- ☐ Mental Health
- ☐ HIV Information
- ☐ Alcohol/Drug Information

Patient Name: _____

Date of Birth: _____

Information to be given to:

Name: _____ Relationship: _____

Address: _____ Phone: _____

This authorization shall remain in effect from the date signed below until (please check one):

- ☐ _____ (specify expiration date or event)
- ☐ NO EXPIRATION DATE

I understand that:

- I may revoke this authorization by contacting ACHC.
- This authorization is giving ACHC the right to discuss my medical information with the individual listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and ACHC will not condition treatment or payment on my providing this authorization.

_____ _____
(Signature) *(Date)*

_____ _____
(Relationship to Patient) *(Date Revoked)*
**If signed by personal representative of patient*

This page was intentionally left blank

ARIA COMMUNITY HEALTH CENTER

ACHC

Patient Rights & Responsibilities
Derechos y responsabilidades del paciente

Patient Rights

1. A patient has the right to considerate, respectful and competent care.
2. A patient has the right to receive, upon request, the name of the person in charge of your care and the name and function of any person providing services to you.
3. A patient or legal guardian has the right to obtain complete and current information concerning your diagnosis, treatment and expected outlook in terms you can be reasonably expected to understand. When it is not medically advisable and/or legally permissible to give such information to you, this information shall be made available to an appropriate person on your behalf.
4. A patient has the right to receive information necessary to give informed consent prior to the start of any procedure and/or treatment, except for emergency situations. This information shall include at minimum an explanation of the specific procedure or treatment itself, its value and significant risks and an explanation of other possible methods, if any.
5. A patient has the right to refuse treatment and to be informed of the medical or other consequences of his/her action.
6. A patient has the right to privacy to the extent consistent with adequate medical care. Case discussions, consultation, examination and treatment are confidential and will be conducted discreetly.
7. A patient has the right to privacy and confidentiality of all records pertaining to your treatment, except as otherwise provided by law or third-party payment contract.
8. A patient has the right to request, examine and receive an itemized explanation of your bill, regardless of source of payment.
9. A patient has the right to counseling regarding the availability of known financial resources for his/her health.
10. A patient has the right to treatment without discrimination based upon race, color, religion, ancestry, national origin, age, sex, genetics, sexual orientation, gender identity, marital status, familial status, disability, veteran status, or any other legally protected group status.
11. A patient who does not speak English will have access to an appropriate interpreter.
12. A patient has the right to receive a copy of these “Patient Rights and Responsibilities.”

Patient Responsibilities

1. Provide a complete health history: ACHC expects you to provide information about your past illnesses, hospital stays, medicines, and other matters related to your health history.
2. Participate in your treatment: Please cooperate with all staff members and ask questions if you do not understand directions or procedures. You are responsible for following the treatment plan upon which you mutually agreed and to express any concerns you may have about following or complying with the proposed care or treatment
3. Comply with Smoke-Free rules: ACHC is responsible for providing a smoke-free environment for the health of all patients and staff. We expect you to obey our smoke-free policy. Be aware that some local governments may assess a fine for smoking.
4. Be courteous to other patients and staff: ACHC is an atmosphere that promotes healing for all patients. To this end, patients are expected to be considerate of other patients and staff members. Behaviors such as vandalism, theft, physical or verbal threats, profanity and disruptive behavior will not be tolerated, and you may be asked to leave the practice.
5. Patients are expected to wear a mask when coming to the office with a complaint of any respiratory illness, fever or other acute illness.
6. Patients are not permitted to bring weapons of any kind onto ACHC property.

ARIA COMMUNITY HEALTH CENTER

ACHC

Patient Rights & Responsibilities
Derechos y responsabilidades del paciente

7 Accept responsibility for payment for all services provided to you by ACHC. Payment may be made through third party payers (such as your insurance company), by self-payment, or by making other payment arrangements for services not covered by insurance. ACHC offers financial counseling services, which includes the sliding fee discount schedule. The sliding discount takes into account family size and income.

8 Communicate with ACHC staff: ACHC staff and patients are committed to the same goal—achieving a positive result. You are responsible for letting our staff know if you have any questions or problems. Please tell us if anything upsets or concerns you while you are receiving care at ACHC. Contact the Site Manager immediately so that your concerns can be addressed.

9 Protect your belongings: You are responsible for the safety of your belongings. ACHC discourages you from bringing valuables to the office.

10 Patients are not permitted to video or audio record without consent from all parties. California is a two-party consent state and recording without permission may violate California law.

Patient Name:		**Signature:**	
Relationship to Patient:		**Date:**	

ARIA COMMUNITY HEALTH CENTER

Wee Dental dentistry for children

HIPAA Notice of Privacy Practices

Revised 10/09/2024

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

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

ARIA COMMUNITY HEALTH CENTER

ACHC

Wee Dental dentistry for children

HIPAA Notice of Privacy Practices

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

REQUESTS TO USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION POTENTIALLY RELATED TO REPRODUCTIVE HEALTH CARE

Reproductive Health Care: Prohibited Uses and Disclosures

ACHC may not use or disclose your PHI for any of the following activities: (i) to conduct a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; (ii) to impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; or (iii) to identify any person for any purpose described in (i) or (ii). For example, if you receive reproductive health care from ACHC under the circumstances in which it is provided, and a health oversight agency or a law enforcement official from another state were to request or subpoena your PHI related to such reproductive health care from ACHC for one of the above prohibited purposes, ACHC would not be authorized to disclose such PHI in response to the request or subpoena.

Uses and Disclosures Conditioned Upon an Attestation:

Additionally, as specified under HIPAA, ACHC may not use or disclose PHI potentially related to your reproductive health care (i) to a health oversight agency, (ii) in the course of any judicial or administrative proceeding (e.g., in response to a court order, subpoena), (iii) to a law enforcement official, or (iv) to a coroner or medical examiner, unless ACHC obtains a valid written attestation from the person requesting your PHI related to reproductive health care. The attestation must verify that the requested use or disclosure of your PHI related to reproductive health care is not otherwise prohibited by HIPAA and complies with HIPAA's requirements.

ARIA COMMUNITY HEALTH CENTER

Wee Dental dentistry for children

HIPAA Notice of Privacy Practices

Special Rules for Minors:

If you are a minor who is legally allowed to consent to healthcare services on your own, ACHC must protect your personal health information (PHI) just as they would for an adult, unless a specific legal exception applies. For instance, ACHC may inform your parent or guardian if your healthcare provider believes that not doing so would seriously jeopardize your health or hinder their ability to treat you. Additionally, if you choose to use your parent's insurance for payment, your parents will receive an Explanation of Benefits from the insurance company, which will disclose that you received services from ACHC. However, if you prefer that your parents are not informed about your services, you need to notify ACHC staff when you receive the services. This way, they can arrange for private or out-of-pocket payment, or check if you qualify for free or discounted care.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Chief Compliance Officer of your complaint at ariacompliance@ariachc.org.
We will not retaliate against you for filing a complaint.

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 www.hhs.gov/ocr/privacy/hipaa/complaints

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our Chief Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Conditions of Registration" form. Please note that by signing the Conditions of Registration form you are only acknowledging that you have received a copy of our Notice of Privacy Practices.