



We are pleased to welcome you as a new patient at Western Sierra Medical Clinic.

To become established, we need your assistance and cooperation in fully completing four forms:

1. Patient Registration
2. Health Questionnaire
3. Consent to Treatment
4. Medical Records Release

In addition, we require your confirmation of receiving and reviewing Western Sierra's New Patient Welcome Packet. The packet explains your rights and responsibilities as a patient and contains policies and disclosures, as required by law.

We look forward to supporting your health and wellness.

Sincerely,

The Staff of Western Sierra Medical Clinic



**CHILD'S NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**PARENT/GUARDIAN NAME(s):** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Which health center do you prefer?**  Grass Valley  Penn Valley  Auburn  Kings Beach  Downieville

**The information requested below will help us to provide better care for your child. Please take time to answer all appropriate questions. We will review the information with you to fill in details. Thank you!**

1. Are there any special concerns about your child's health now?      Yes       No
2. Does your child take any medications at this time?      Yes       No
3. Your child's birth weight: \_\_\_\_\_ Was he/she born at full term?      Yes       No
4. Were there complications during your pregnancy with this child?      Yes       No   
 (e.g. infections, use of drugs, medications)
5. Was the labor or delivery complicated?      Yes       No   
 (e.g. Cesarean delivery, breech position, baby needing oxygen)
6. Did your child have problems as a newborn      Yes       No   
 (e.g. jaundice, breathing trouble, infection)
7. Has your child ever been hospitalized?      Yes       No
8. Has your child ever had surgery?      Yes       No
9. Has your child had serious injuries?      Yes       No
10. Has your child had other medical problems?      Yes       No
11. Is your child allergic to anything (e.g. to medications)?      Yes       No
12. Are your child's vaccines up-to-date?      Yes       No
13. Have there been any unusual reactions to vaccines?      Yes       No
14. Have you ever felt that your child's growth or development were faster or slower than other children at the same age?      Yes       No

**In the family (including the mother's and the father's families), are there any of the following?**

1. Allergy problems or asthma      Yes       No
2. Deafness      Yes       No
3. Diabetes requiring insulin      Yes       No
4. Cystic Fibrosis      Yes       No

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 5. Infant deaths   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6. Mental retardation  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7. Strokes or heart attacks<br>(Before age 50 in males or 60 in females) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 8. High blood cholesterol  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 9. High blood pressure   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 10. Other medical problems in the family                                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Mother and Father are: Married  Separated  Divorced  Remarried

Mother's occupation:

Father's occupation:

Who lives in your child's household?

Are you concerned about your child's behavior at this time? Yes  No

**Please check any of the following symptoms that have been present in the last year:**

- |   |   |
|---|---|
| <input type="checkbox"/> Weight loss or change of appetite  | <input type="checkbox"/> Recurring fevers without explanation |
| <input type="checkbox"/> Severe headaches                   | <input type="checkbox"/> Frequent constipation                |
| <input type="checkbox"/> Chronic cough or trouble breathing | <input type="checkbox"/> Vision, hearing, or speech problems  |
| <input type="checkbox"/> Muscle weakness                    | <input type="checkbox"/> Joint pain, swelling, or limp        |
| <input type="checkbox"/> Recurring abdominal pains          | <input type="checkbox"/> Unusual skin rashes                  |
| <input type="checkbox"/> Painful or excessive urination     |   |

**Other complaints or concerns?**

**Nutrition (please leave blank):**

Western Sierra Medical Clinic does not discriminate on the basis of race, color, national origin, sex, age or disability, ethnicity, religion, culture, language, sex, physical or mental disability, socioeconomic status, sexual orientation, or gender identity or expressions.



---

**Patient's Name**

---

**Date of Birth**

The undersigned, as the above patient or as the parent, legal guardian or legal representative of the above patient, hereby consents to medical treatment of the above patient by Western Sierra Medical Clinic (WSMC) and its medical providers and clinical staff. Treatment may include any necessary examination, test or medical procedure a WSMC medical provider in the exercise of his/her best judgment may deem advisable for the above patient to be performed by WSMC clinical staff. I understand and acknowledge this authorization is given in advance of any specific diagnosis, treatment or procedure being required to provide specific consent to any and all such diagnosis, treatment or procedure a WSMC medical provider in the exercise of his/her best judgment may deem advisable for the above patient.

I understand the above patient may ask questions and have all questions answered and also may refuse treatment at any time.

If the above patient is seeking substance abuse testing, I authorize WSMC to obtain a specimen pursuant to proper medical protocol to determine the presence of drugs or alcohol.

I understand that some physical exams (like fitness for duty, school, or sports) and other services are not intended to diagnose medical conditions or replace the medical care of the above patient's personal physician.

This authorization shall remain effective for one year from the date signed, unless sooner revoked in writing.

---

**Patient, Parent, Legal Guardian or**

---

**Print Full Name**

---

**Date**

**Legal Representative Guarantor Signature**

This page is intended to be blank.

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, your health provider may not use or disclose your individually identifiable health information, and in the case of Western Sierra Medical Clinic except as provided in its Notice of Privacy Practices, without your authorization. By completing this form, you are giving permission for the use and disclosure described below.

Please review and complete this form carefully. It may be invalid if not accurately or fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

PLEASE NOTE: Separate authorizations may need to be completed as you indicate below authorization for releasing certain portions of health information for varying purposes. You do not need to use this form for all purposes. Please complete separate authorizations as appropriate.

**PATIENT DATA**

Full Name of Patient (Please Print): \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Other Names Used by Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_

*By signing below you acknowledge that you have read and understand all of the above.*

_____	____/____/____
Patient Name	Patient Date of Birth
_____	____/____/____
Patient or Guardian Signature	Print Full Name
	Date

**AUTHORIZATION – HEALTH INFORMATION TO BE RELEASED BY FORMER CARE PROVIDER:**

I am establishing care with Western Sierra Medical Clinic and request that you release and disclose records pertaining to my medical care with you, other than treatment records pertaining to psychotherapy, mental health, alcohol or drug use, and HIV test results that will not be disclosed unless specifically requested in a separate request:

Releasing/Disclosing Party:

Facility/Physician Name: \_\_\_\_\_

Patient ID: \_\_\_\_\_ Medical Records #: \_\_\_\_\_ Account #: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Fax: \_\_\_\_\_

Receiving Party:

Western Sierra Medical Clinic  
844 Old Tunnel Road  
Grass Valley, CA 95945  
Phone: 530-274-9762  
Fax: 530-273-7255

Western Sierra Medical Clinic does not discriminate on the basis of race, color, national origin, sex, age or disability, ethnicity, religion, culture, language, sex, physical or mental disability, socioeconomic status, sexual orientation, or gender identity or expressions.

This authorization is effective for one (1) year from the date of signature unless a different date is specified here: \_\_\_\_\_

This authorization may be revoked upon written request, but any revocation will not apply to information disclosed before receipt of the written request.

A copy of this authorization is as valid as the original. I have the right to receive a copy of this authorization.

**NOTICE: Once the requested health information is disclosed, any disclosure of the information by the recipient may no longer be protected under the federal HIPAA Privacy Rule. Under California law, all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

If not signed by the patient, please indicate relationship to the patient (check one, if applicable):

- Parent or guardian of minor patient who could not consent to health care
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient
- Spouse or person financially responsible (where information solely for purpose of processing application for dependent health care coverage)

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_



**Print Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

*Most of these consents, policies, and disclosures refer to  
a page number in the "New Patient Welcome Packet"*

### Notice of Privacy Practices

\_\_\_\_\_ (Patient Initials) WSMC's Notice of Privacy Practices is posted in the lobby of each WSMC facility and on the WSMC website. A copy can be furnished to you upon request. I read and understand WSMC's Notice of Privacy Practices.

### No-Show Policy

\_\_\_\_\_ (Patient initials) I received, read and understand the WSMC policies about "No Shows." **(Page 3)**

### Patient's Rights and Responsibilities

\_\_\_\_\_ (Patient initials) I received, read and understand the Patient's Rights and Responsibilities. **(Pages 4 & 4a)**

### Notice and Acknowledgement of Prescription Protocol

\_\_\_\_\_ (Patient initials) I received, read and understand WSMC policy regarding controlled substances **(Page 5)**

### Consent for Billing, Release and Assignments

\_\_\_\_\_ (Patient initials) All co-payments, deposits and sliding fees are due and payable at the time of check-in. I assign all insurance payments to be made directly to WSMC. This authorization and assignment is a permanent, one-time consent. I reserve the right to revoke this at any time with my written notice. **(Pages 6 & 6a)**

\_\_\_\_\_ (Patient initials) I authorize the release of information from approved claim forms to an insurer or authorized agency as well as medical information needed to determine benefits or benefits payable to related services. I also permit a copy of this authorization to be used in place of the original.

### Consent to Test in the Event of Accidental Health Provider Exposure to Potential Blood-borne Pathogens:

\_\_\_\_\_ (Patient initials) I consent to the performance of a blood test if my health provider is accidentally cut or suffers a needle stick in the course of my treatment.

### Verification that you have received the "New Patient Welcome Packet"

\_\_\_\_\_ (Patient initials) I received, understand and agree with all of the information in the New Patient Welcome Packet.

### Notices, policies and procedures subject to change

\_\_\_\_\_ (Patient initials) The above notices, policies and procedures are subject to change.

**Can confidential messages be left on your voice mail?** \_\_\_\_\_ Yes \_\_\_\_\_ No

**Signature of Patient, Parent or Legal Guardian:** \_\_\_\_\_ **Date** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**WSMC Staff Signature:** \_\_\_\_\_



## **Welcome to Western Sierra Medical Clinic!**

Western Sierra Medical Clinic, Inc. (WSMC) has been providing health care services in our community since 1979. From health centers in Downieville and Grass Valley, we have added a site in Penn Valley and expanded into Placer County with locations in Auburn and Kings Beach-Tahoe. While we have grown, our mission to provide high quality health care, regardless of a patient's ability to pay, has remained constant. We have a team of first-rate medical, dental and behavioral health providers who are part of the community and are committed to each patient's health and wellness.

## **Important Patient Information**

The contents of this packet spell out the policies, conditions and requirements for a patient at WSMC. It is important for every patient to read and confirm their acceptance of specific policies, disclosures and consents listed on the New Patient Confirmations form. These are requirements of WSMC and the laws and regulations that govern health center operations.



**Board of Directors**

Chair  
Larry Allen

Vice-Chair  
Scott Browne

Treasurer  
Richard Kuhwarth

Secretary  
Derek Williams

Anita Daniels

Doug McDonald

Katherine Medeiros

Rob Oldham, MD

Brandon Pangman

Dr. Jon Peek

Lupe Peterson

Don Russell

**Executive  
Management**

Chief Executive Officer  
Scott McFarland

Welcome to Western Sierra Medical Clinic!

I want to personally welcome you to our growing health center. I am proud to share with you the quality of medicine our providers have been giving to our patients for many years.

Our health center has provided comprehensive care for more than 40 years to patients of a variety of ages, conditions and insurances. We are excited to extend our commitment to excellent care to you.

I have worked for many years as a physician for Western Sierra providing care for our patients. As Chief Medical Officer, I am devoted to continuing a tradition of better health to an ever-growing population, which now includes you!

Our caring, well-trained medical staff are dedicated to keeping you as healthy as possible, including wellness care and chronic disease management, as well as the medical issues that come up unexpectedly and require Urgent Care.

We look forward to meeting you.

To your good health,

Heather Lucas-Ross, MD  
Chief Medical Officer

Western Sierra Medical Clinic does not discriminate on the basis of race, color, national origin, sex, age or disability, ethnicity, religion, culture, language, sex, physical or mental disability, socioeconomic status, sexual orientation, or gender identity or expressions.

Rev. 5.22.17

**Nevada County**

844 Old Tunnel Road, Grass Valley, CA 95945  
10544 Spenceville Road, Penn Valley, CA 95946  
CoRR, 180 Sierra College Drive, Grass Valley, CA 95945

**Placer County**

3111 Professional Drive, Auburn, CA 95603  
12183 Locksley Lane, Suite 106, Auburn, CA 95602  
Kings Beach-Tahoe, 8665 Salmon Ave., Kings Beach, CA 96143

**Sierra County**

209 Nevada Street, Downieville, CA 95936



**WSMC has established a “No-Show” policy in order to maintain quality health care to all patients of the health center.**

## Medical

For Medical services, a no-show is when a patient calls and cancels an appointment less than 24 hours before the appointment or the patient does not show up for a scheduled appointment.

- After two no-shows, a patient will be placed on scheduling probation, which means the patient will be able to schedule appointments but must call and confirm the appointment the day before.
- If the patient does not confirm the appointment, the appointment will be cancelled.
- If the patient shows for the unconfirmed appointment, the patient will not be seen.
- If the patient does not show for an appointment after confirming it, the patient will be considered for discharge from the practice.
- After a patient on scheduling probation demonstrates a pattern of attending appointments consistently, he or she can be considered for removal from scheduling probation.

## Dental

For all Dental services, after two no-shows within one year (cancelled appointment with less than 24 hours’ advance notice and/or not showing up for a scheduled appointment), the patient will not be able to schedule another appointment and may not be permitted to receive care at WSMC.

## Behavioral Health

For Behavioral Health services, if a patient does not show for an appointment once, he or she will not be able to schedule another appointment and instead would be on stand-by status (the patient can come in and wait for an opening to occur) or call-in status (call in the morning to see if there is an opening on the same day). If a patient fails to show for a call-in appointment, he or she can be considered for discharge from Behavioral Health services (although he or she could still be seen for medical and dental services).

Western Sierra Medical Clinic (WSMC) is committed to providing quality of care to our clients and their families. We encourage patients to be aware of their rights and responsibilities as listed below:

## You Have the Right to:

1. Receive considerate, respectful, and culturally appropriate care based on professional standards of practice.
2. Receive services without discrimination on the basis of race, color, sex, marital status, religion, age, handicap, sexual orientation or preference, national origin, ancestry or diagnosis.
3. Establish advance directives and participate in ethical decision making.
4. Receive an explanation of your diagnosis, treatment, and prognosis in terms and language you can understand.
5. Receive the necessary information to participate in decisions about your care and to give your informed consent before any diagnostic or therapeutic procedure is performed.
6. Refuse any treatment, except as prohibited by law, and to be informed of the consequences of making this decision, which may include informing Children, Youth, and Family Services or Protective Services.
7. Expect that your personal privacy will be respected by all staff.
8. Expect that your medical records will be kept confidential and information will be released only with your written consent, in cases of medical emergencies, or in accordance with law.
9. Know WSMC policy for accessing and disclosing information in your medical records and reviewing your medical record, upon request, at a mutually designated time.
10. Receive a full explanation of any research or experimental procedure proposed for treatment and the opportunity to give your informed consent before any procedure will begin.
11. Know the name and qualification of all individuals providing service and how to contact that person.
12. Obtain another medical opinion prior to any procedure.
13. Have your legal custodian access your written medical records by appointment.
14. Ask for and receive information on your financial liability and an explanation of charges, including services that will be charged to your insurance.
15. File a complaint about services rendered without fear of discrimination from WSMC by submitting a written complaint or by calling WSMC's Chief Communications Officer at (530) 273-4984 ext. 106 between 8:30 a.m. and 4:30 p.m.

Western Sierra Medical Clinic does not discriminate on the basis of race, color, national origin, sex, age or disability, ethnicity, religion, culture, language, sex, physical or mental disability, socioeconomic status, sexual orientation, or gender identity or expressions.



## You are Responsible for:

1. Providing accurate personal, financial, insurance and medical information, including all medications and treatments, necessary to establish and follow your plan of care.
2. Asking questions if you do not understand the explanation of your diagnosis, treatment, prognosis or any instructions.
3. Informing WSMC of any requirements or accommodations needed to meet your cultural and/or language needs.
4. Following rules and regulations that are posted within WSMC while in the facility.
5. Not carrying any type of weapons when receiving treatment.
6. Not harming or being abusive to other persons including WSMC staff.
7. Keeping all scheduled appointments, arriving on time, and being able to participate in treatment.
8. Notifying WSMC with 24 hours' advance notice or as soon as you are aware that you cannot keep an appointment.
9. Informing WSMC health care professionals regarding any changes or reactions to medication and/or treatment.
10. Paying for services promptly including co-payments and total of cash charges at the time of service.
11. Advising WSMC of any problems or dissatisfaction with the service being provided.
12. Extending to WSMC staff the same courtesy given to you.
13. Developing and participating in your treatment planning.
14. Providing for the supervision and safety of your children while in the facility.
15. Keeping WSMC apprised of your current contact information.
16. Not videotaping or recording any WSMC staff.

Western Sierra Medical Clinic does not discriminate on the basis of race, color, national origin, sex, age or disability, ethnicity, religion, culture, language, sex, physical or mental disability, socioeconomic status, sexual orientation, or gender identity or expressions.



## Notice and Acknowledgement of Prescription Protocol

As a new patient to our health center, please note that your provider will make a comprehensive assessment of your health, and will work to create a health plan to best meet your health needs.

Your provider may or may not choose to prescribe the same medications that you may have been prescribed to you in the past. Our providers utilize current best practices and information to create treatment plans. You and your provider may agree that your medical condition may benefit by the prescription of controlled medication(s). The main goal of using a controlled medication is to improve your physical and vocational functioning. If these goals are not met, the medication will be discontinued. The use of controlled medications can lead to chemical dependency and possibly addiction. You and your provider will discuss the side effects of the medication(s) and the manner by which it is to be used.

If you are already dependent on controlled substances, your provider will expect you to submit urine for a drug test at your first visit. Your provider will also check the prescription drug monitoring program to determine the history of your prescription activities in the past year.

If you are currently taking **Suboxone** or **Buprenorphine**, it will be necessary for you to be referred to our Medication-Assisted Treatment (MAT) program. This could potentially delay our ability to schedule you immediately with one of our primary care providers.

During the initial evaluation, your WSMC provider may determine that the previous medications prescribed by a different provider are not appropriate, are not safe, or are causing more harm than good. If that is the case, your WSMC provider will explain the treatment plan options, which may include referral to detoxification services, tapering doses, discontinuation of medications, alternative pain management techniques, or substituting medications. If you are not in agreement with the options presented to you, you are welcome to seek care for your condition that has been treated with controlled substances elsewhere.

When prescribed a controlled substance at WSMC you will be asked at the time of your first prescription and on an annual basis to sign a treatment agreement, which is a standardized agreement that ensures that you are aware of the expectations to keep your medications secure, to take your medications as prescribed and to avoid potential dangerous situations. A copy of this agreement is available by request.

Please sign below to acknowledge that you have read this information and agree to work within this Western Sierra Medical Clinic policy.

In our continuing efforts to provide a medical home and continuity of care, we look forward to a long and mutually beneficial health relationship.



---

## Financial Responsibility for Health Center Services (Credit Policy)

It is the patient's responsibility to pay their share of charges provided by WSMC. This means that co-payments are due and payable at the time of appointment. Except as noted, any other balances must be paid in full within thirty (30) days of the statement date.

### Willingness to Pay

No one will be denied medical, dental or other clinic services at WSMC because of an inability to pay so long as there is a "willingness" to pay. Willingness means a commitment to follow a payment plan, as needed, in order to pay off any outstanding balance within 90 days. In the absence of a demonstrated willingness to pay, a patient's account will be assigned to an outside collection agency. When an account is sent for collection, the patient may be required to pay a deposit on the day of service prior to being seen for any future visits or be dismissed as a patient.

### Uninsured Patient Discount

WSMC offers a 20 percent discount to uninsured patients, if charges are paid in full at the time of appointment.

### Sliding Fee

For patients who qualify, a sliding scale discount may be applied for the current visit and for the next six months. A sliding scale discount may also be applied when the sliding fee application is completed for the date of service and the required proof of insurance is submitted within the 15-day calendar grace period. Please see a WSMC Billing staff member for any questions regarding the sliding fee scale.

### Assignment

WSMC cannot bill insurance carriers in situations such as an automobile accident. However, WSMC will provide information to submit a claim. WSMC accepts assignments on Medicare and Medi-Cal claims but cannot make assurances that charges will be covered by the insurance carrier.

### Patient Share of Charges

The patient/guardian/representative is responsible for co-payments, co-insurance, deductibles, and charges not covered or approved by the patient's insurance carrier, whether or not the carrier is contracted with WSMC. However, as a courtesy, non-contracted insurance carriers may be billed for reimbursement by WSMC on the patient's behalf. Insurance coverage can be confusing and WSMC staff is committed to helping patients answer any questions.

Western Sierra Medical Clinic does not discriminate on the basis of race, color, national origin, sex, age or disability, ethnicity, religion, culture, language, sex, physical or mental disability, socioeconomic status, sexual orientation, or gender identity or expressions.





## Identity and Insurance Verification

Patients are required to provide WSMC with correct insurance information and to verify current personal information (home address, employer, phone number, insurance cards, and photo ID) at the time of appointment check-in. **It is important that you bring proof of insurance each time you visit. Failure to do so may result in you not being seen or being required to make a full payment at the time services are rendered.**

## Payment

WSMC accepts cash, checks or major credit cards. Checks should be made payable to Western Sierra Medical Clinic.

**A \$25.00 fee will be charged for the first check returned by the bank and a service fee of up to \$35 for each subsequent check returned by the bank to that same payee [Cal. Civ. Code 1719 (2003)].**

## Special Circumstances

In an emergency situation, services may be provided by a WSMC provider to a patient regardless of the patient's account status. However, services will be provided only for such an emergency situation.

## Authorization for Release and Assignment of Benefits

Payment of authorized Medicare, Medi-Cal, government and any other third party benefits made on your behalf and/or on behalf of all members covered on your insurance plan will be made directly to Western Sierra Medical Clinic, on services furnished by your health provider.

If other health insurance coverage is indicated in the CMS-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, we require your signature to authorize release of the information to the insurer or agency shown, to release medical information to determine benefits or benefits payable to related services, and to permit a copy of this authorization to be used in place of the original.