APPOINTMENT CHECKLIST

Bond Community Health Center, Inc.

1720 S. Gadsden Street. Tallahassee FL 32301. P (850) 576-4073 / f (850)-576-2824

Thank you for choosing Bond Community Health Center, Inc. for your healthcare needs. Attached you will find our registration packet and brochure, please complete the forms and forward them to the front desk receptionist or bring them with you on the day of your office visit.

Gather documents to bring to your doctor's visit. **To make appointments all intake documents must be on file.**

Adult New Patients:

•Photo ID, Insurance Card, Social Security Card

•Any laboratory tests results, x-rays or EKG's

•Current list of your medications and dosages, including over the counter medications/vitamins

Pediatric New Patients

•Photo ID of parent/legal guardian ◦Legal guardianship documentation is required

•Insurance Card

•Birth Certificate

•Social Security Card ◦Patient and Parent/Legal Guardian

•Any laboratory tests results, x-rays or EKG's

•Current list of your medications and dosages, including over the counter medications/vitamins

Existing Patients

•Photo ID and Insurance Card

Financial Assistance / Uninsured Patients

BCHC's goal is to help you access healthcare and maintain wellness regardless of your ability to pay. We provide services on a Sliding Fee Scale for those patients who qualify. Patients must submit financial documentation annually to be eligible. If you have financial concerns about receiving services, please ask to see the BCHC Eligibility Specialist.

Documentation required at the time of service or prior to qualify for the Sliding Fee Scale:

•Photo ID

•Social Security Card

•Proof of Residence (Home Mailing Address/Dorm) (official credential i.e. Drivers licenses, Voters ID card,

•Proof of Income (Pay Stub/SSI/Disability/Financial Aid/Government Assistance i.e. food stamps) (NOTARIZED LETTER FROM YOUR BENEFACTOR OUTLINING SUPPORT IN FULL > AMOUNT AND RESIDENCY INFORMATION TO BE INCLUDED)

***** In case of life-threatening emergencies, call 911 or go to the nearest emergency room or hospital *****
When you need to speak with the provider on call, dial (850) 576-4073.
***** Notice for the Federal Tort Claims Act (FTCA) Considered as a Health Center *****
This health center is a beneficiary of the Health Centers Program under 42 U.S.C. 254b, and an employee of the Public Health Service estimated under 42 U.S.C. 233 (g) - (n)

Bond Community Health Center, Inc.

Mission Statement

Our mission is to provide access to quality healthcare for all people in our community.

Value Statement

Bond Community health Center, Inc. is committed and obligated to providing the highest quality care services to all community and surrounding community residents in an atmosphere of dignity and respect, and treat all patients with a truly caring attitude. We will always be aware of the changing needs of the community and strive to be responsive to those needs. We will promote policies and procedures that uphold a continuum of care for all. We embrace human differences as bonds not barriers and believe that quality health care should be universally accessible. The values that have persisted over time is a strong sense of community, dignity of all person, value of employees, commitment to serve and importance of family.

Leadership Statement

Bond Community Health center's leadership is devoted to promoting the well-being of our Human Capital through a comprehensive health and stress reduction perspective involving the physical, social, emotional and spiritual domains. We will continue to strive to improve effectiveness and efficiency of all staff members by providing training, development and employee empowerment. Management is committed to vesting each employee to realize our mission and attain the Center's goals and objectives.

BOND COMMUNITY HEALTH CENTER, INC. PATIENT'S RIGHTS & RESPONSIBILITIES

We at Bond Community Health center, stand committed to a mission of healing and hospitality. This commitment is evidenced through the care we provide in accordance with the patient's rights and responsibilities listed below. They are recognized as those rights of all adult, pediatric and adolescent patients, their parents and or guardians. Any patient, parent or guardian who feels the patient is not being treated properly is encouraged to discuss the situation with the doctor, nurse or administrative representative. A complaint will no way affect the quality of care given the patient.

PATIENT'S RIGHTS

You have the right to;

1. Be treated with dignity, respect and support on your decision;

2. Obtain from your physician complete current information concerning your diagnosis, treatment and prognosis in terms you can understand and the right to know the identity and professional status of all healthcare workers;

3. Participate in all aspects of your care, including refusing or limiting care;

4. May change providers if other qualified providers are available;

5. Receive from your physician information necessary to give informed consent prior to the start of any procedure and or treatment. Where medically necessary significant alternatives for care or treatment exist, or when you request information concerning medical alternatives, you have the right to such information. You also have the right to know the name of the person responsible for the procedure;

6. Refuse treatment to the extent permitted by law, and to be informed of the medical consequences of your action;

7. Expect that your cultural, psychosocial and personal values will be respected;

8. Participate in the consideration of ethical issues that may arise;

9. When medically permissible, to be transferred to another facility only after you have received pertinent information and an explanation concerning the need for the alternatives to such a transfer;

10. Impartial access to care, regardless of race, national origin, religion, age, creed, gender, disability or sources of payment;

11. Entitled to full financial information relating to your care;

12. To be advised and refuse if the health center proposes to engage in or perform human experimentation or other research projects affecting your care or treatment;

13. Formulate advance directives and to appoint a surrogate to make health care decisions on your behalf to the extent permitted by law;

14. To discuss methods for providing feedback, including complaints, contact the Chief Compliance Officer, Gabriel Otuonye, MHA, LHRM, CMCO, CHA at (850), 576-4073, Ext 232 or email gotuonye@bondchc.com.

15. What health center rules and regulations apply to you as a patient,

16. Privacy and confidentiality of all patient information.

PATIENT RESPONSIBILITES

1. In order to receive optimal care; you and your family are responsible to:

2. Request clarification when necessary to fully understand your health problems and the proposed plan of action;

3. Provide information for insurance and work with this healthcare facility to make payment arrangements when necessary;

4. Accept personal financial responsibility for any charges not covered by insurance;

5. Provide accurate information about your present illness, medications, past medical history including hospitalizations and unexpected changes in your condition;

6. Follow through on your agreed plan of care, including keeping your appointments. If that is not possible, cancel at least 24 hours in advance.

7. Follow the rules and regulations of the healthcare facility.

8. Be considerate and respectful to the rights of others.

9. To respect the property of the healthcare facility, including medical supplies/equipment, the building, furnishings, and grounds.

10. Provide complete and accurate information about your identity, demographics, income, insurance, and answer other reasonable questions that will assist the center in providing appropriate care and obtaining payment. This includes reviewing and signing all necessary consents, financial agreements, or other documents required by the healthcare facility.

CENTER RULES and REGULATIONS:

1. Everyone must wear shoes and shirts and pants must be at or above the waistline while on the centers property.

2. Respect the designated areas for food, drinks, smoking, and parking. Cars illegally parked or abandoned will be ticketed or towed at the owner's expense.

3. There will be no alcohol, drugs, and/or weapons permitted on the premises. Patients who arrive at the center under the influence and do not require urgent care will be asked to leave. If they refuse, law enforcement will be contacted for assistance.

4. Parents are asked to supervise their children, both inside and outside the facility. Parents will be held responsible for the actions of their children.

5. If you are dissatisfied with services rendered, please do not take it out on our staff. Discuss your concerns with the appropriate person.

6. Financial arrangements should be made regarding your bill at the time of service.

7. Appropriate conduct is expected by all the patients, visitors at all times. Threatening, violent, abusive, disruptive or loud behaviors are inappropriate. The center reserves the right to ask you and your family/guest to leave or have you removed from the property.

Bond Community Health Center, Inc.

1720 S. Gadsden St.
Tallahassee, Fl. 32301
www.bondchc.com

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

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

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

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

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

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• If you want to file a complaint or have questions about this notice, please contact the Chief Compliance Officer, Gabriel Otuonye, MHA, LHRM, CMCO, CHA at (850) 576-4073, Ext. 232 or email: gotuonye@bondchc.com. You may also send your complaint by mail at the address provided on page 1.

Your Choices

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

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases, we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

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

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

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

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual die.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our pledge regarding Health Information:

We understand that health information about you is personal. We are committed to protecting your health information. We create a record of the care and services you received from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by this health care, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to health information we keep about you and describe certain obligations we have regarding the use and disclosure of your health information.

Florida statutes, rules and regulations requires certain limits and restrictions imposed on disclosure of your protected health information. We will abide by those rules in order to protect your health information.

Our Responsibilities

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

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

Changes to the Terms of this Notice

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

September 12, 2013, Revised July 2019

This Notice of Privacy Practices applies to the following organizations.

Bond Community Health Center, Inc. and it's Satellite offices:

Kay Freeman Health Center
Bond on Magnolia
Bond Community Health Center Mobile Unit
Bond Specialty & Community Wellness Center

- You can complain if you feel we have violated your rights by contacting us using the information on page 2.
- 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 will not retaliate against you for filing a complaint.

PATIENT REGISTRATION FORM

GENERAL INFORMATION

Patient Name _____ **SSN:** _____ **DOB:** _____
First name Last Name Initial

Address _____ **Phone** _____ **Email** _____

City _____ **State** _____ **Zip Code** _____

Sex: M ☐ **F** ☐ **Age** ___ **Marital Status** _____ **Ethnicity: (Hispanic/Latino):** ____**Yes** ____**No**

Race: (circle one) Asian American Indian Black Pacific Islander White
Multi Other: (specify) _____

Primary Language: _____ **U.S. Veteran?** _____**Yes** _____ **No**

Do you need help with translation? ☐ **Yes** ☐ **No** **Do you have any physical disabilities:** _____ **Yes** ____ **No**
If yes, do you need any special help? _____

Responsible Party _____ **Employed By** _____

Business Name _____ **Business Phone** _____

Monthly Income _____ **Number of Dependents** _____

SOURCE OF INCOME: EMPLOYMENT_____**AFDC: $**_____ **SSI: $**_____ **CHILD SUPPORT: $** _____
SOC. SEC: $ _____ **SELF EMPLOYED: $** _____ **UNEMPLOYMENT: $** _____**OTHER (specify)**_____

YOUR LEVEL OF EDUCATION: ☐ **High School not Complete** ☐ **High School Diploma** ☐ **College Education**

Emergency Contact Name: _____ **Phone Number:** _____

Other person/s authorized to bring your child to the doctor: _____ **Relationship:** _____

INSURANCE INFORMATION (Please present ID card at check-in)

MEDICARE# _____ **MEDICAID #** _____

Private Insurance Company: _____**HMO:** _____

Contract#: _____ **Group#:** _____ **Subscriber#:** _____

Name of Insured _____ **Employed by** _____
First Name Last Name

Relation to Patient _____ **Social Security Number:** _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that all the information provided is accurate. I understand that I am financially responsible for any and all charges not covered by insurance of the program for which I qualify. I hereby authorize Bond Community Health Center to release any information to collect payment of benefits. I authorize the use of this signature on all payment and insurance submissions.

_____ _____
Patient/Legal Guardian Signature **Date**

_____ _____
Witness Signature **Date**

GENERAL CONSENT FOR TREATMENT

I, THE UNDERSIGNED, GRANT PERMISSION FOR MYSELF OR MINOR CHILD(REN) TO UNDERGO ALL NECESSARY TESTS, EXAMINATIONS, TREATMENTS, AND OTHER PROCEDURES REQUIRED IN THE COURSE OF STUDY, DIAGNOSIS, AND TREATMENT OF ILLNESS BY MEDICAL PRACTITIONERS AND OTHER STAFF MEMBERS OF BOND COMMUNITY HEALTH CENTER, INC.

I AM AWARE THAT THE PRACTICE OF MEDICINE AND MINOR SURGERY IS NOT AN EXACT SCIENCE AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS A RESULT OF TREATMENTS OR EXAMINATION BY BOND COMMUNITY HEALTH CENTER, INC.

I CONSENT TO THE RELEASE OF MEDICAL AND DEMOGRAPHIC INFORMATION TO AUTHORIZED INSTITUTIONS OR GOVERNMENTAL AGENCIES AS IS REQUIRED BY BOND COMMUNITY HEALTH CENTER, INC.

I HEREBY AUTHORIZE PAYMENT TO BOND COMMUNITY HEALTH CENTER, INC OF BENEFITS OTHERWISE PAYABLE TO ME; OF MEDICAID; MEDICARE AND THIRD PARTY INSURANCE BENEFITS, BUT NOT TO EXCEED THE HEALTH CENTER'S REGULAR CHARGES FOR THIS PERIOD OF TREATMENT.

_____ _____

(PATIENT OR LEGAL GUARDIAN) **DATE**

_____ _____

(INTAKE SPECIALIST – WITNESS) **DATE**

CLIENT PARTICIPATION AGREEMENT

This is to certify that _____ Social Security Number
Patient Name
_____and the following members of his/her family may

receive services from Bond Community Health Center, Inc.

FAMILY MEMBERS	SOCIAL SECURITY NUMBER	DATE OF BIRTH

The following services are offered: Physical Exams, Screenings, Prescription Medicine, Prenatal Care, X-Rays, Immunizations, Pediatric Care, STD/STI Screening and Treatment, HIV Testing and Treatment, Nutritional Counseling, Health Education, Behavioral Health, Well and Sick Care, Medical Follow-up and Dental Services.

These services have been explained to me. I understand that although I or other members of my family may be referred for specialty care, hospitalization or high level care, there is no obligation for the provider to pay for these services. I understand that I may be responsible for my family and me. I will notify Bond Community Health Center, Inc. when one of my family members cannot keep an appointment.

I certify that all information I have given regarding income and family size are true and correct to the best of my knowledge. I understand that any slide scale discount that I qualify for will be in effect for 12 months unless there are significant changes in income or household size. After that time, I will be required to re-apply. I also understand that any falsification of documentation may result in my being charged full cost of receiving services.

_____ Yes, I would like to apply for a sliding fee discount

_____ No, I do not wish to apply for a sliding fee discount

_____ _____
(Patient or Legal Guardian) **Date**

_____ _____
(Intake Signature as Witness) **Date**

Bond Community Health Center – Patient Health History

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

Age: _____ **Birthday:** _____ **Date of Last Physical Examination:** _____

What is your reason for this visit? _____

REVIEW OF SYMPTOMS: **Check symptoms you currently have or have had in the past year.**

GENERAL
- □ Chills
- □ Depression
- □ Dizziness
- □ Fainting
- □ Fever
- □ Forgetfulness
- □ Headache
- □ Loss of Sleep
- □ Loss of Weight
- □ Nervousness
- □ Numbness
- □ Sweats

GASTROINTESTINAL
- □ Appetite Poor
- □ Bloating
- □ Bowel Changes
- □ Constipation
- □ Diarrhea
- □ Excessive Hunger
- □ Gas
- □ Hemorrhoids
- □ Indigestion
- □ Nausea
- □ Rectal Bleeding
- □ Stomach Pain
- □ Vomiting

EYE, EAR, NOSE, THROAT
- □ Bleeding Gums
- □ Blurred Vision
- □ Difficulty Swallowing
- □ Double Vision
- □ Ear Ache
- □ Ear Discharge
- □ Hay Fever
- □ Hoarseness
- □ Loss of Hearing
- □ Nosebleeds
- □ Persistent Cough
- □ Ringing in Ears
- □ Sinus Problems
- □ Vision – Flashes
- □ Vision – Halos

MUSCLE/JOINT/BONE

Pain, weakness, and/or numbness in:
- □ Arms □ Hips
- □ Back □ Legs
- □ Feet □ Neck
- □ Hands □ Shoulder

CARDIOVASCULAR

Pain, weakness, and/or numbness in:
- □ Chest Pain
- □ High Blood Pressure
- □ Irregular Heart Beat
- □ Low Blood Pressure
- □ Poor Circulation
- □ Rapid Heart Beat
- □ Swelling of Ankles
- □ Varicose

GENITO-URINARY
- □ Blood in Urine
- □ Frequent Urination
- □ Lack of Bladder Control
- □ Painful Urination

SKIN
- □ Bruise Easily
- □ Hives
- □ Itching
- □ Change in Moles
- □ Rash
- □ Scars
- □ Sore That Won't Heal

CONDITIONS: **Check conditions you currently have or have had in the past year.**
- □ AIDS/HIV
- □ Alcoholism
- □ Anemia
- □ Anorexia
- □ Arthritis
- □ Asthma
- □ Bleeding Disorder r
- □ Bronchitis
- □ Bulimia
- □ Cancer
- □ Cataracts
- □ Chicken Pox
- □ Diabetes
- □ Emphysema
- □ Epilepsy
- □ Glaucoma
- □ Goiter
- □ Gout
- □ Heart Disease
- □ Hepatitis
- □ Hernia
- □ Herpes
- □ High Cholesterol
- □ Kidney Disease
- □ Liver Disease
- □ Headaches
- □ Mononucleosis
- □ Multiple Sclerosis
- □ Mumps
- □ Pacemaker
- □ Pneumonia
- □ Polio
- □ Prostate Problems
- □ Psychiatric Care
- □ Rheumatic Fever
- □ Scarlet Fever
- □ Stroke
- □ Suicide Attempt
- □ Thyroid Problems
- □ Tonsillitis
- □ Tuberculosis
- □ Ulcers
- □ Vaginal Infections
- □ Venereal Disease/STD/STI

WOMEN ONLY

Are you pregnant □ Yes □ No

Age at Onset of Period: _____

Menstrual Flow: □ Regular □ Irregular □ Cramps

_____ Days of Flow _____ Length of Cycle

1st Day of Last Period _____

□ Pain/Bleeding during or after sex

Number of:

____ Pregnancies _____ Abortions

____ Miscarriages _____ Live Births

Birth Control Method: _____

Date of last PAP test: _____

□ Normal □ Abnormal

MEN ONLY
- □ Breast Lump
- □ Erectile Difficulties
- □ Lump in Testicles
- □ Penis Discharge
- □ Sore on Penis

MEDICATIONS: List Medications you are currently taking

MEDICATIONS	MEDICATIONS	ALLERGIES

FAMILY HISTORY:

Disease	Relationship to you
Anemia	
Arthritis	
Asthma	
Cancer	
Diabetes	
Heart Disease	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

HOSPITALIZATIONS/SURGERY:

Year	Reason for Hospitalization/Surgery

Violence/Abuse in the Family? □ Yes □ No

Have you ever had a blood transfusion? □ Yes □ No

If yes, please give approximate dates: _____

Tuberculosis: PPD date _____ Results _____ mm _____ CXR(date) _____ Results _____

HEALTH HABITS:

Tobacco Use: □ Yes □ No Amount _____ Stopped(date) _____

Alcohol Use: □ Yes □ No Amount _____

Street Drugs: □ Yes □ No Type _____ Amount _____

Exercise: □ Yes □ No Describe _____

Seat Belt Use: _____ Always _____ Sometimes _____ Never

SEXUAL HISTORY:

More than 1 partner in past 5 years?	□Yes	□ No	More than 1 partner in past year?	□ Yes	□ No
Sex with male	□Yes	□ No	Victim of Sexual Assault	□ Yes	□ No
Sex with female	□Yes	□ No	Sex w/injection drug user?	□Yes	□ No
Sex while using non-injection drugs	□Yes	□ No	Sex w/man who had sex w/man?	□Yes	□ No
Sex for drugs/money?	□Yes	□ No	Sex with person with HIV/AIDS	□Yes	□ No

CONTRACEPTIVE HISTORY

Method last used/using now _____
Other method used _____
Problem with method? _____

Staff Signature/Title _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____, have received the Notices of
Print Name

Privacy Practices from Bond Community Health Center, Inc.

_____ _____
Patient/Legal Guardian Signature Date

In lieu of patient signature, I, _____, a staff member

of Bond Community Health Center, Inc., state that _____

has received our current Notice of Privacy Practices.

_____ _____
Intake Specialist Date