Community Health Center
OF SNOHOMISH COUNTY

ARLINGTON CLINIC
326 S Stillaguamish Ave
Arlington, WA 98223
360-572-5400

EDMONDS CLINIC
23320 Hwy 99
Edmonds, WA 98026
425-640-5500

EVERETT-CENTRAL CLINIC
4201 Rucker Ave
Everett, WA 98203
425-382-4000

EVERETT-COLLEGE CLINIC
930 N Broadway
Everett, WA 98201
425-595-3900

EVERETT-NORTH CLINIC
1424 Broadway
Everett, WA 98201
425-789-2000

EVERETT-SOUTH CLINIC
1019 112th St SW
Everett, WA 98204
425-551-6200

LYNNWOOD CLINIC
4111 194th St SW
Lynnwood, WA 98036
425-835-5200

ADMINISTRATION
8609 Evergreen Way
Everett, WA 98208
425-789-3700

chcsno.org

Hello,

Welcome to Community Health Center of Snohomish County (CHC)!

We are happy you chose us to be your healthcare home. At CHC, we work hard to provide patient-centered care. Patient-centered care means that we look at the whole you, from your physical needs to your mental health needs. We will partner with you to offer care that is respectful of your values, culture, and preferences.

This packet is given to all patients who are new to CHC. In it you will find important information about your patient experience.

The contents of this packet include:

- Welcome Letter (this document)
- Patient Rights and Responsibilities
- Notice of Privacy Practices
- Notice of Nondiscrimination
- No Show Patient Notice- Medical
- No Show Patient Notice- Dental
- Patient Acknowledgment and Consent- **must be signed**

Please make sure to review all documents, as well as sign and return the Patient Acknowledgement and Consent form on last page.

Questions? Ask a member of your care team or a CHC front desk staff member if you have questions or need assistance in any way.

Thank you for choosing CHC of Snohomish County! We look forward to working with you on your healthcare journey.

Sincerely,

Your care team at CHC

Patient Rights and Responsibilities

YOU HAVE THE RIGHT TO:

- Quality care and service.
- Be treated with respect and dignity.
- Not be discriminated against.
- Speak with a provider regarding emergency medical / dental needs after business hours.
- Complete information about your health and your choices for treatment and service. We will give this information to you in a language and manner you can understand.
- Take part in decisions about your health care. If you refuse treatment, we will explain the possible results.
- Ask about fees, charges, and payment policies.
- Refuse to take part in research.
- Suggest changes in procedures.
- Take part in choosing your primary care provider.
- Participate in decisions about your plan for end-of-life care.
- Complain if you have concerns about any clinic services.
- File a grievance if you are not satisfied with how your complaint is resolved.
- File a grievance if you feel you have experienced unprofessional conduct from any employee.
- Have your health information disclosed as allowed by law.
- To have access to, request to make amendments to, and obtain information on disclosures of your health information, in accordance with applicable law.
- Reasonable notice if CHC decides to change or end its relationship with you.

YOUR RESPONSIBILITIES ARE TO:

- Give correct and complete medical history and billing information.
- Inform your provider about any living will, medical power of attorney, or other directives that could affect your care.
- Keep scheduled appointments. If you need to cancel, call us 24 hours before the appointment.
- Do your part to keep yourself as healthy as possible by following treatment plans and care instructions you agreed to with your health care provider.
- Treat staff and other patients with respect.
- Respect the privacy of others.
- Respect CHC's property.
- Abide by the policies of CHC.
- Pay for services received as per CHC policies.
- Pay for the services you received when referred to other health care providers outside of CHC.
- Watch and keep safe any children you bring to the health center.

Failure to meet these responsibilities may result in inability to access future services from CHC.

CHC Community Health Center OF SNOHOMISH COUNTY

Notice of Privacy Practices

Introduction

This notice describes how Protected Health Information (PHI) may be used and disclosed and how you can get access to this information. Please review it carefully.

By law, Community Health Center of Snohomish County (CHC), is required to:

- Protect the privacy of your information.
- Provide this notice about our privacy practices.
- Follow the privacy practices described in this notice.
- Notify you if your patient health information has been compromised.

For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end.

Uses and Disclosures Without Your Written Authorization

Here are some examples of how we may use and share your PHI without your authorization.

Contact You: We may use PHI to contact you. to remind you of your appointments, provide test results, let you know about treatment options, or let you know about health education events or services.

Treatment: We may use and disclose PHI in order to provide treatment to you. We may also share your PHI with other health care providers who care for you for continuity of care.

Payment: We may use or disclose PHI for the purposes of determining coverage, billing, claims management, and reimbursement. We may also share your PHI to request or receive payment from your health insurance plan.

Health Care Operations: We may use or disclose PHI to support the business activities of your healthcare provider and CHC, including sharing your PHI with third party "business associates" that perform activities for our organization such as billing and transcription services. We may also use or disclose your PHI as necessary, to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you.

Fundraising: We may use PHI to contact you to raise money for our operations. We may also disclose PHI to a foundation that is related to us so that the foundation may contact you to raise money for its operations. Any fundraising materials sent to you will include a description of how you may opt out of receiving any further fundraising communications.

Required or Permitted by Law: We may use or disclose PHI when we are required or permitted to do so by law. We may also disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Other disclosures permitted or required by law include:

- Healthcare oversight agencies for licensing and auditing
- Public health activities
- Health oversight activities
- Law enforcement when required or allowed by law
- Research when approved by an institutional review board
- Workers' compensation claims
- Military or national security agencies
- Coroners, medical examiners, and funeral directors

Uses and Disclosures Without Your Authorization, but You Can Object

In the event of your incapacity or emergency circumstances, we will disclose PHI consistent with your prior expressed preference that is known to us, and in your best interest as determined by our professional judgment. We will also use our professional judgment and our experience to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions,

Family and Other Persons Involved In Your Care: We may use or disclose PHI to notify or assist in locating a family member or another person responsible for your care to notify them of your location, general condition, or death.

Disaster Relief Efforts: We may use or disclose protected PHI to a public or private entity authorized by law or its charter to assist in disaster relief efforts for the purpose of coordinating notification of family members of your location, general condition, or death.

Uses and Disclosures Requiring Your Written Authorization

Psychotherapy Notes: We must obtain your authorization for any use or disclosure of psychotherapy notes, except if our use or disclosure of psychotherapy notes is: (1) by the originator of the psychotherapy notes for treatment purposes, (2) for our own training programs in which mental health students, trainees or practitioners learn under supervision to practice or improve their counseling skills, (3) to defend ourselves in a legal proceeding initiated by you, (4) as required by law, (5) to a health oversight agency with respect to the oversight of the originator of the psychotherapy notes, (6) to a coroner or medical examiner; or (7) to prevent or lessen a serious and imminent threat to the health or safety of a person or the general public.

Reproductive Privacy: We must adhere to privacy laws when using or disclosing health information that is a part of any reproductive health record. Unless authorized by law, we will never share any reproductive health record without your written permission.

Notice of Privacy Practices

Substance Abuse Disorder Records: We must adhere to federal law when using or disclosing health information that is a part of any substance abuse treatment record. Unless authorized by law, we will never share any substance abuse treatment record without your permission.

Marketing Communications. We must obtain your written authorization before using PHI for marketing or the sale of PHI, consistent with the definitions and exceptions set forth in the Health Insurance Portability and Accountability Act (HIPAA).

Other Uses and Disclosures. Uses and disclosures other than those described in this Notice will only be made with your written authorization. You may revoke any such authorization at any time by providing us with written notification of such revocation.

Your Individual Rights

Right to Inspect and Copy. You may request access to your medical records and billing records maintained by us in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny access to your records. We may charge a fee for the costs of copying and sending you any records requested.

Right to Alternative Communications. You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

Right to Request Restrictions. You have the right to request a restriction on PHI we use or disclose for treatment, payment, or health care operations. You must request any such restriction in writing addressed to the Risk Manager (Privacy Officer), 8609 Evergreen Way, Everett, WA 98208. We are not required to agree to your request, except if your request is to restrict disclosing PHI to a health plan for the purpose of carrying out payment or health care operations, the disclosure is not otherwise required by law, and the PHI pertains solely to a health care item or service which has been paid in full by you or another person or entity on your behalf.

Right to Accounting of Disclosures. Upon written request, you may obtain an accounting of disclosures of PHI made by us in the last six years, subject to certain restrictions and limitations.

Right to Request Amendment. You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by mailing a request to Community Health Center of Snohomish County, 8609 Evergreen Way, Everett, WA 98208 at any time.

Right to Receive Notification of a Breach. We are required to notify you if we discover a breach of your unsecured PHI, according to requirements under federal law.

Questions or Complaints

If you want further information about your privacy rights or are concerned that your privacy rights have been violated, you may contact our Risk Manager (Privacy Officer) at (425) 789-3775. You may also file a written complaint with the of the U.S. Department of Health and Human Services, Office for Civil Rights (OCR).

There will be no retaliation for filing a complaint with either our practice or the OCR. The address for the OCR regional office for Washington is as follows:

Office for Civil Rights
U.S. Department of Health and Human Services
2201 Sixth Avenue - M/S: RX-11
Seattle, WA 98121-1831

Effective Date and Changes to This Notice

Effective Date. This Notice is effective on **May 21,2024**.

Changes to this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in the waiting area of our office and on our web site at **www.chcsno.org**. You may also obtain any revised notice by contacting Community Health Center of Snohomish County, 8609 Evergreen Way, Everett, WA 98208

Notice of Nondiscrimination

Discrimination is against the law.

Community Health Center of Snohomish County (CHC)complies with applicable Federal civil rights laws and does not exclude, treat people differently, or discriminate on the basis of race, color, national origin, age, disability, or sex.

We provide:

- Free resources and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you believe we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Community Health Center of Snohomish County's Risk Manager is available to help you.

Community Health Center of Snohomish County
8609 Evergreen Way
Everett, WA 98208
425-789-3789, TTY 711, Fax: 425-789-3780

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by mail, phone, or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at www.hhs.gov/ocr/office/file/index.html

Notice of Subsection 224 (o) of the Public Health Service Act
The legal liability of the health care practitioner is limited pursuant to the Public Health Service Act (section 224(q)(1)(D)).

This notice, from The Secretary of Health and Human Services, is to provide information in regard to Community Health Center of Snohomish County's liability protection and does not constitute, a comprehensive notice pertaining to any provision of the Act except to the extent of the clinic's implementation of the Act.

Community Health Center
OF SNOHOMISH COUNTY

Notice of Nondiscrimination

English	If you speak a language other than English, or if you are hard of hearing, deaf, or deaf/blind, we will provide an interpreter for free. Call 1-425-789-3789 (TTY:711).
Amharic	ከእንግሊዘኛ ውጭ ሌላ ቋንቋ የሚናገሩ ከሆነ ወይም ለመስማት የሚከብዶት፣ መስማት የተሳናቸው ወይም መስማት የተሳናቸው / ማየት የተሳናቸው ከሆኑ የትርጉም አገልግሎት በነጻ እንሰጣለን። ወደ 1-425-789-3789 (TTY:711) ይደውሉ።
Arabic	إذا كنت تتحدث لغة بخلاف اللغة الإنجليزية، أو إذا كنت تعاني من صعوبة في السمع، أو كنت أصم، أو أصم/كفيفًا، فإننا سنقوم بتوفير مترجم فوري بشكلٍ مجاني. اتصل بالرقم 1-425-789-3789 (الهاتف النصي:711).
Cambodian	ប្រសិនបើលោកអ្នកនិយាយភាសាផ្សេងក្រៅពីភាសាអង់គ្លេស ឬប្រសិនបើលោកអ្នកគ្រាថៀកធ្ងន់ ថ្លង់ ឬថ្លង់/ពិការភ្នែក យើងខ្ញុំនឹងផ្តល់ជូនសេវាអ្នកបកប្រែផ្ទាល់មាត់ដោយឥតគិតថ្លៃ។ សូមហៅទូរសព្ទទៅលេខ 1-425-789-3789 (TTY:711)។
Chinese	如果您講英語以外的語言，或者您是聽力障礙人士、失聰人士或失聰/失明人士，我們將免費提供口譯員。請致電 1-425-789-3789 (TTY: 711) 。
German	Falls Sie die englische Sprache nicht sprechen oder nicht ausreichend verstehen sollten, oder falls Sie schwerhörig, taub oder taub-blind sein sollten, stellen wir Ihnen kostenlos einen Dolmetscher oder eine Dolmetscherin zur Verfügung. Bitte rufen Sie an: 1-425-789-3789 (TTY:711).
Japanese	英語以外の言語を話される方、または耳の遠い方、耳が聞こえない方、耳と目の両方に障がいのある方は、無料で通訳を手配いたします。1-425-789-3789（TTY:711）までお電話ください。
Korean	영어 이외의 언어를 사용하거나 청각 장애나 시각 장애가 있으신 분들을 위해 통역사를 무료로 제공해드립니다. 1-425-789-3789(TTY:711) 로 전화하세요.
Laotian	ຖ້າທ່ານເວົ້າພາສາອື່ນນອກຈາກພາສາອັງກິດ ຫຼື ຖ້າທ່ານບໍ່ໄດ້ຍິນດີ, ຫູໜວກ ຫຼື ຫູໜວກ/ຕາບອດ, ພວກເຮົາຈະຈັດຫາບາຍພາສາໃຫ້ຟຣີ. ໂທຫາ 1-425-789-3789 (TTY: 711).
Marshallese	Elaññe kwōjelā juon kajin im eoktak jen Kajin Pālle, ñe e jab elaññe ejabwe am jelā roñ, kwōjaroñroñ, ak kwōjaroñroñ/pilo, kōmnaaj bōktok juon ri-ukok im ejjeḷok wonen. Kūrḷok 1-425-789-3789 (TTY:711).
Portuguese	Para outros idiomas que não o inglês, ou em caso de deficiência auditiva, deficiência visual ou ambas, é fornecido gratuitamente o serviço de interpretação. Ligue para 1-425-789-3789 (TTY:711).
Punjabi	ਜੇਕਰ ਤੁਸੀਂ ਅੰਗਰੇਜ਼ੀ ਤੋਂ ਇਲਾਵਾ ਕੋਈ ਹੋਰ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ, ਜਾਂ ਜੇਕਰ ਤੁਹਾਨੂੰ ਸੁਣਨ ਵਿੱਚ ਮੁਸ਼ਕਿਲ ਹੈ, ਬੋਲ਼ੇ ਜਾਂ ਬੋਲ਼ੇ/ਅੰਨ੍ਹੇ ਹੋ, ਤਾਂ ਅਸੀਂ ਮੁਫ਼ਤ ਵਿੱਚ ਦੁਭਾਸ਼ੀਆ ਪ੍ਰਦਾਨ ਕਰਾਂਗੇ। 1-425-789-3789 (TTY:711) 'ਤੇ ਕਾਲ ਕਰੋ।
Russian	Если вы не говорите по-английски или являетесь слабослышащим, глухим или слепоглухим, мы бесплатно предоставим вам услуги переводчика. Позвоните по телефону 1-425-789-3789 (телетайп: 711).
Spanish	Si habla un idioma distinto al inglés, o si tiene problemas de audición, es sordo o sordo/ciego, le proporcionaremos un intérprete de forma gratuita. Llame al 1-425-789-3789 (TTY: 711).
Somali	Haddii aad ku hadasho luuqad aan ahayn Ingiriisi, ama haddii maqalku kugu adag yahay ama aad tahay dhagool, ama dhagool/indhoole, waxaan kusiin doonaa turjumaan bilaash ah. wac 1-425-789-3789 (TTY:711).
Tagalog	Kung ikaw ay nagsasalita sa isang wika maliban sa Ingles, o kung mahina ang iyong pandinig, bingi, o bingi/bulag, magbibigay kami ng interpreter nang libre. Tumawag sa 1-425-789-3789 (TTY:711).
Ukrainian	Якщо ви не розмовляєте англійською мовою, або якщо ви погано чуєте, є глухою чи сліпоглухою особою, ми надамо вам перекладача безкоштовно. Телефонуйте за номером 1-425-789-3789 (TTY: 711).
Vietnamese	Nếu bạn không nói được tiếng Anh hoặc nếu bị lãng tai, điếc hoặc điếc/mù, chúng tôi sẽ cung cấp dịch vụ thông dịch miễn phí. Hãy gọi 1-425-789-3789 (TTY:711).

OPS FORM 202A 0424

No-Show Patient Notice: Medical

Keeping scheduled appointments is an important part of your health care. It allows your medical provider to talk about your medical care and what you can do to stay healthy. When you miss an appointment, not only do you also miss out on the opportunity to improve your health, but it also takes the appointment away from another patient who may need it.

No-Show Patient Notice: Dental

Keeping scheduled appointments is an important part of your dental care. It allows your dentist or hygienist to talk to you about your oral health and what you can do to stay healthy. When you miss an appointment, you also miss out on the opportunity to improve your health. In addition, it takes the appointment away from another patient who may need it.

- Patients of Community Health Center of Snohomish County who do not show up for their appointment will receive the following: a letter, phone call, and/or text notifying them of their missed appointment.
- Patients may be put on probation if they fail to show up for or call to cancel their appointment three (3) or more times within a six (6) month period. While on probation, patients will not be able to make appointments in advance for six (6) months unless approved by a dental practice manager. However, they will be able to come into the office to request a same-day appointment if swollen or in pain.
- Possible termination of a patient if they have been placed on probation three (3) or more times.

We hope this notice helps you understand the importance of keeping your appointments and/or providing adequate notice when you need to cancel. Your oral health is important to us, and we look forward to seeing you at your next scheduled appointment.

OPS Form 304B (7/24)

Patient Acknowledgement and Consent Form

Release of Medical Information:
I authorize my care team to leave health information such as test results, medication information, and/or answers to my question on my answering system.

Communication Consent:
I consent to receive all forms of communication from my care team. CHC may call, text, email, or mail me important information such as appointment reminders, test results, treatment options, or health education services or events. I understand I can choose to opt out at any time.

Consent to Care:
I consent to the plan of care proposed by my care team. I understand that I, or my authorized representative, have the right to decide to accept or refuse this plan. I will ask questions as needed and will make my wishes known.

Notification of Release for Payment:
I understand that CHC will provide any diagnosis and information required to assure payment from insurance companies and any liable third-party payers. I understand that, unless expressly limited by me in writing, this may include all aspects of treatment including testing and/or treatment for HIV/Aids, sexually transmitted diseases, substance abuse or mental health conditions.

Financial Agreement:
I understand co-payments are due at the time of service. I assign payment from my insurance directly to CHC.
I understand I am financially responsible to CHC for the charges not paid by insurance and that those charges are due within 30 days of invoice. I understand that in addition to the bill from my provider, I may also receive separate bills from the laboratory, radiology and other specialized services.

Receipt of Notice of Health Information Practices:
I have been offered a copy of CHC Privacy Practices informing me of my rights related to the protection of my health information. I have also been offered a copy of the No Show Policy, informing me of the importance of keeping my appointments and the consequences if I do not cancel when I am unable to make it.

Patient Rights and Responsibilities:
I have been offered a copy of CHC's Patient Rights and Responsibilities, which provides me with information about being a patient at CHC.

Telehealth Care
I understand that telehealth visits are billable and that CHC will follow all patient privacy laws. If an in-person visit is required, I will be notified. I understand that if the electronic connection is lost, which may cause issues with privacy, my care team will call me back at the number that I have provided.

By signing below, you agree to all of the information above.

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(if patient is a minor)