Community Access Registration Packet

North Olympic Healthcare Network
240 West Front St | Suite A
Port Angeles, WA 98362-2609
(360) 452-7891 P | (360) 452-8087 F

Frequently Asked Questions

What is NOHN Community Access?
Some patients may not have access to healthcare due to time, transportation, or lack of a primary care provider, insurance, or knowledge about healthcare needs. North Olympic Healthcare Network (NOHN) partners with community organizations to reduce these barriers and improve access to care by deploying staff to locations where these barriers are present.

Community Access sometimes involves deploying NOHN's Mobile Health Clinic (MHC). The most current schedule for Community Access is available online at *mobile.nohn-pa.org*.

What happens at NOHN Community Access Points?
NOHN is constantly adjusting and improving the services it offers, including those offered. Currently, Community Access registrants are able to access the following services:

- **Behavioral Health Counseling** - Patients who register for Community Access do not need to fully establish with a NOHN Primary Care in order to be seen by a behavioral healthcare provider for a virtual telehealth counseling appointment. Support staff will assist patients to facilitate virtual appointments as needed.
- **Medical** - At partnered sites, participants with **urgent** needs who don't have a Primary Care Provider (PCP), or who are not able to get in with their PCP in a timely manner, can schedule an appointment to be seen by NOHN's same-day medical provider within 48 hours. If requested, patients can be assisted establishing with a NOHN PCP.
- **Dental Screenings** - NOHN Family Dentistry conducts planned dental screening events in the community. If any oral health issues are found during a patient's screening, the patient has the option of scheduling promptly for sealants or other treatment. If a patient is interested in receiving a dental screening, they may fill out and sign the optional Oral Health Screening and Fluoride Varnish Consent Form on Page 4 of this packet.
- **Outreach and Navigation** - NOHN maintains a team of navigators who participate in outreach, assist patients in signing up and scheduling their appointments, and educate and connect patients to resources that address barriers to care such as lack of health insurance coverage, transportation to medical appointments, inadequate housing, etc.

Will patient information be shared?
North Olympic Healthcare Network (NOHN) keeps a record of the healthcare services provided to you. We use your health information primarily for the purposes of treatment, payment, and healthcare operations. We will NOT disclose your protected health information to others or for other purposes unless you direct us to do so, or unless the law authorizes or compels us to do so.

Patients can obtain a full version of the Notice of Privacy Practices (NPP) from NOHN by contacting us at (360) 912-6770 or emailing MHC@nohn-pa.org. Additionally, the NPP is available at the Mobile Health Clinic location or in our brick-and-mortar clinic locations. More information regarding our privacy practices is available on our website: *www.nohn-pa.org/for-patients/privacy-practices/*

How are patients supposed to pay for services?
No one will be denied service due to inability to pay. NOHN navigators can assist you in obtaining health insurance if needed. If the patient does not have insurance and does not qualify for coverage, we can provide sliding fees for certain services. To learn more, schedule a meeting with a navigator at *calendly.com/nohn-mhc-navigator/appointment*

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****Please complete the entire form. Incomplete forms may result in a delay or denial of services.****

Patient Information

Legal Name _____
Preferred Name _____
Date of Birth _____ School/Site _____
Grade (If a student) _____ Sex _____
Race _____ Ethnicity _____
Address _____
Primary Doctor/PCP _____
City _____ State _____ Zip _____
Preferred Phone # _____
Preferred Email _____

Is there an alternative contact?
Name _____
Preferred Phone # _____
Relationship _____

I would like NOHN to call and/or *text* me for scheduling and appointment reminders:

☐ Yes ☐ No

Services Sought: ☐ Medical ☐ Behavioral Health ☐ Dental ☐ Vision

Insurance/Billing Information

Does patient have health insurance? ☐ Yes ☐ No
Insurance Plan/Company _____
Policy Number _____
Group Number _____
Subscriber Name _____
Subscriber Date of Birth _____
Subscriber's Relationship to Patient _____
Phone # _____
Address _____
City _____ State _____ Zip _____

Other Information

Housing Situation –
Patient has steady housing: ☐ Yes ☐ No

Patient lives with: (Check all that apply)

☐ Mother ☐ Grandparent(s) ☐ Legal Guardian
☐ Father ☐ Foster Parent(s) ☐ Other
☐ Emancipated Minor

In the past 2 years, has seasonal/migratory work been your or your family's main source of income?

☐ Yes ☐ No

REQUEST TO DISCLOSE PHI / PERSONAL HEALTH INFORMATION (FOR SCHEDULING ONLY)

To better coordinate your care, NOHN requests your consent to release limited, scheduling-related medical and behavioral health information to school/site staff:

I, _____ (DOB) _____ authorize and give my permission for my protected health information to be shared with site staff to coordinate my care. Only information necessary to facilitate scheduling and communications about appointments is authorized. This release may include office staff, counselors, nurses, teachers, and school navigators. I understand that I may amend or revoke this at any time in writing and that the changes or revocation will take effect immediately upon my request.

Signature of Authorizing Representative **Date**

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Before medical health services are provided to a youth, NOHN **MUST** have this signed Consent Form signed by a parent or legal guardian.

According to law, MINORS (people under 18 years old) may provide their **own** consent for substance abuse treatment and mental health care services at the age of 13 or older. MINORS may provide their **own** consent for reproductive health care at any age. If necessary, NOHN will inform youth of options for outside care and will assist youth in discussing these issues with parents/guardians.

When a minor consents for their own care, all information is kept confidential and cannot be released except in the following circumstances when it can be confidentially shared:

- If the patient shows signs of risk of suicidal behavior.
- If the patient has a life-threatening health problem and is under 18 years old.
- If the patient gives us permission through a signed release of information.
- If the patient plans to do serious bodily harm to someone else.
- If there is reason to suspect abuse or neglect. This may include any sexual contact with a minor bya person older than 18 or where this is a three - or more - year difference in ages.

Please note: The student's consent is LEGALLY required for release of information about the following: pregnancy, sexually transmitted disease (including HIV/AIDS testing), substance abuse treatment, and/or mental health counseling.

NOHN encourages students to involve their parents or guardians in healthcare decisions whenever possible. If necessary, NOHN will assist students in discussions with their parents or guardians. As noted above, minors may consent to certain confidential healthcare services without parental permission.

For patient: Do you need services to be CONFIDENTIAL? ☐ Yes ☐ No
If yes, I understand this limits who can receive information about my care, that I will be contacted by NOHN staff directly, and that I may start or stop confidential services at any time.

I understand that the following types of services may be offered through NOHN Community Access:

- *Behavioral health counseling*
- *Dental screenings*
- *Health education, counseling, and/or wellness promotion*
- *Immunizations*
- *Referral for healthcare services that cannot be provided on the Mobile Health Clinic*

I give permission to North Olympic Healthcare Network (NOHN) to perform medical and/or therapeutic procedures as needed or advised for my (or my child's) health screening, diagnosis, and treatment. I understand that a patient record will exist.

I understand that NOHN Community Access is not a free service and that NOHN will bill my insurance company. Anything not paid by the insurance company will be billed to me.

By signing below, I am also acknowledging that:

- *I am either the patient or the patient's personal representative.*
- *I have received a copy of the Notice of Privacy Practices for North Olympic Healthcare Network.*
- *I understand that I may contact the person named in the Notice of Privacy Practices if I have questions about the contents of the Notice.*

Patient Signature **PRINTED Patient Name** **Date**

Parent/Guardian Signature **PRINTED Parent/Guardian Name** **Date**

Dental Screening Consent Form

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*****If the patient requesting a dental screening is a MINOR, this Oral Health Screening & Fluoride Varnish Consent Form must be signed by the patient's parent, guardian, or representative.*****

Patient Information

Full Name _____
Date of Birth _____
Preferred language _____
Preferred Phone # _____

Parent/Guardian/Representative Information

Full Name _____
Date of Birth _____
Preferred language _____
Preferred Phone # _____

Insurance/Billing Information

Insurance Plan/Company _____
Policy Number _____
Group Number _____
Subscriber Name _____
Subscriber Date of Birth _____
Subscriber's Relationship to Patient _____
Would the patient like assistance applying for insurance or NOHN's Sliding Fee Scale? (If yes, a NOHN Outreach Worker will attempt to contact you) ☐ Yes ☐ No

I understand that by signing this form I am consenting for the patient named above to receive a basic oral health assessment, or dental screening. I understand that this screening is only a very basic evaluation and does not take the place of a thorough dental examination necessary to establish and maintain oral health.

I also understand that receiving this dental screening does not establish any new, ongoing, or continuing doctor-patient relationship. I am free to establish such a doctor-patient relationship in the future with the dentist performing this screening or another dentist of my choice. Further, I will not hold the dentist or those performing this assessment responsible for the oral health consequences or results should I choose NOT to follow the recommendations of the provider.

☐ **I do consent for a fluoride varnish to be applied to the patient's teeth.**

☐ **I do NOT consent for a fluoride varnish to be applied to the patient's teeth.**

☐ **I would like to establish the patient and/or myself as a patient at North Olympic Healthcare Network Family Dentistry. Please contact me to discuss next steps.**

Parent/Guardian/Representative's Signature **Date Signed**

North Olympic Healthcare Network is a Federally Qualified Health Center (FQHC), a special type of community health center. We offer care to everyone, regardless of their demographics or circumstances.

There is a Patient Demographic Questionnaire (PDQ) on the back side of this form. Completing the PDQ helps us to fulfill our mission as a community health center, and to meet our requirements as an FQHC. We keep your answers to the PDQ private and secure, and only use this information in a way that does not identify individuals. If you are filling out the PDQ on behalf of another person (spouse, child, etc.), please complete the sections based on the patient's information.

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