Neighborhood Health Centers of the Lehigh Valley

Neighborhood Health Centers of the Lehigh Valley

At Neighborhood Health Centers of the Lehigh Valley our goal is to help patients learn to navigate the complicated world of health care, strengthen connections with their clinicians, and set and accomplish goals that improve their quality of life, and as a Federally Qualified Health Center and a Patient-Centered Medical Home, we strive to provide quality care in a safe environment, regardless of one's ability to pay.
www.nhclv.org

NHCLV - Allentown
Casa Guadalupe
218 N 2nd St
Allentown PA 18102
Tel: 610-841-8400 Fax: 610-841-8401

Hours
Monday 8 AM – 8 PM
Tuesday 8 AM – 8 PM
Wednesday 8 AM – 4:30 PM
Thursday 8 AM – 8 PM
Friday 8 AM – 4:30 PM
Two Saturdays a month 8 AM – 1 PM

Lanta Buses 220 and 324 stop nearby

NHCLV – Bethlehem
Fowler Family Center at Donegan
1210 E 4th St
Bethlehem PA 18015
Tel: 484-408-0755 Fax: 484-408-0756

Hours
Monday 8 AM – 4:30 PM
Tuesday 8 AM – 8 PM
Wednesday 8 AM – 4:30 PM
Thursday 8 AM – 8 PM
Friday 8 AM – 4:30 PM
One Saturday a month 8AM – 1 PM

Lanta Bus 105 stops right in front

NHCLV - Easton
Two Rivers Health and Wellness
1101 Northampton St
Easton PA 18042
Tel: 484-544-3113 Fax: 484-544-3114

Hours
Monday 8 AM – 4:30 PM
Tuesday 8 AM – 8 PM
Wednesday 8 AM – 8 PM
Thursday 8 AM – 4:30 PM
Friday 8 AM – 4:30 PM
One Saturday a month 8AM – 1 PM

Lanta Bus 220 and 106 stop right in front

Services Offered

- Physical Exams (Children and Adults)
- Care Management for patients with Chronic Illness
- Well Woman - Pap smears, birth control
- Pregnancy tests and Prenatal Care
- Preventive Screenings and Vaccines
- STD Testing and Treatment
- Care Coordination
- Mental Health Counseling
- Psychiatry
- Dental Clinic
- Help applying for insurance and public benefits (social security, SNAP, housing)
- Diagnosis & treatment of common illnesses using evidence-based care guidelines
- Group health classes
- Center of Excellence

If you need help when the offices are closed:

- If it is a medical emergency, call 911 or go to the nearest emergency room.
- If it is not a medical emergency, please call the main number to speak with our answering service who will contact an on-call doctor/nurse for urgent needs. Be sure to provide a good call back number.
- If your need is urgent, the on-call doctor will call you back. Please stay by your phone. If it is not an urgent matter, they will give us the message and we will call you back within two business days.
- If you are in labor, the answering service will contact one of the doctors providing your prenatal care, and someone will return your call as soon as possible.

Neighborhood Health Centers of the Lehigh Valley (NHCLV) serves all patients regardless of ability to pay. Discounts for essential services (sliding fee) are offered depending on family size and income. To apply for a discount, please complete page 3.

COMMUNITY HEALTH CENTER FQHC QUALITY SM

No Show Policy

Our goal is to offer the best possible care to our patients, so we are concerned when you are unable to keep a scheduled appointment. Please let us know as soon as possible, at least 24 hours before, if you will be able to keep your scheduled appointment. This will help us take care of other patients.

Our no-show policy is as follows:

1st No-Show: We know stuff happens.

2nd No-Show: Is something getting in the way of keeping your appointments with us? A letter will be sent to you letting you know this is your second no-show and you will have to speak to our Office Coordinator to reschedule your appointment.

3rd No-Show: Sorry but we need to make other arrangements now. You will get a letter letting you know this is your third no-show and we need to make special arrangements for your following appointment. You will be double-booked for all of your appointments which means you will be squeezed into our schedule and seen when your provider is available. Or you may be offered a same-day appointment if one is available.

Patients' Rights and Responsibilities Statement

Patients' Rights

- Be treated with dignity and respect, and acknowledged as an individual with unique health care needs.
- Be treated fairly regardless of race, color, national origin, religion, disability, gender, age, citizenship status, sexual orientation, gender identify, or source of payment
- Receive care in a clean and comfortable environment.
- Have cultural, ethnic, psychological, spiritual and personal beliefs, values and preferences, learning needs and language preferences acknowledged and respected.
- Know the name, education and title of the staff serving you.
- Consent to or refuse any care or treatment.
- Receive an understandable explanation of your health condition or status
- Receive information in your language and free of charge
- Have your medical and personal information treated confidentially.
- Involve family members and/or significant others in care decisions as you request and as appropriate.
- Be actively involved and make shared decisions in your treatment plan
- Be encouraged to share questions and concerns
- Receive services regardless of ability to pay and on a sliding scale basis.

Patients' Responsibilities

- Treat NHCLV staff with courtesy and respect, and show appreciation for their cultural, ethnic, psychosocial, spiritual and personal values.
- Be honest about your medical, dental, sexual and mental health history.
- Ask questions until you understand what you need to know about your health care.
- Express any concerns about your ability to follow the proposed plan of care.
- Accept the consequences and outcomes if you do not follow the care, treatment and service plan.
- Report any changes in your health condition to your medical provider.
- Provide feedback about your service needs and expectations.
- Respect clinic staff and property, and comply with the clinics' rules and regulations.
- Keep appointments or cancel at least 24 hours in advance.
- Accurately represent and report your true financial situation and earnings.
- Pay patient fees when services are rendered, or take responsibility to make payment arrangements

Your Information. Your Rights. Our Responsibilities.

This Notice of Privacy Practices describes how medical information about you may be used and released and how you can get access to this information. Please read it carefully.

Your Rights

Get a copy of your health and claims records - We will give you a copy or a summary of your health and claims records, usually within 30 days of your request. We can charge a fee for the copy of your records.

Correct your health and claims records - You can ask us to correct your health and claims records if you think they are wrong or incomplete. We can say "no" to your request, but we will tell you why in writing within 60 days.

Request confidential communication - You can ask us to contact you in a specific way (like call home instead of your cell phone) or to send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit the information we 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.

Get a list of those with whom we've shared your information - You can ask for a list 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 list all the times we shared your information except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). You can get a free list once a year, if you ask for another list within 12 months of the last list, we can charge you a fee.

Get a copy of this privacy notice - You can ask for a paper copy of this notice at any time

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 have to make sure the person has this authority and can act for you before we take any action.

File a complaint if you believe your privacy rights have been violated - You can complain if you feel we have violated your rights by contacting calling our Quality Management Program at 610-820-7605. 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.

We will never share any substance abuse treatment records without your written permission

Your Choices

You have both the right and choice to tell us to share information with your family, close friends, or others involved in payment for your care and share information in a disaster relief situation. 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. We can never share your information unless you give us written permission for marketing purposes or the sale of your information.

Our Uses and Disclosures

We may use and share your information as we: help manage the health care treatment you receive, run our organization, pay for your health services, administer your health plan, help with public health and safety issues, do research, comply with the law, respond to organ and tissue donation requests and work with a medical examiner or funeral director, address workers' compensation, law enforcement, and other government requests, respond to lawsuits and legal actions.

NHCLV 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**.**

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, on our web site, and we will mail a copy to you. Any questions, please call Quality Management Program at 610-820-7605.

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Patient Information Today's Date: _____ MRN_____

Full Legal Name: _____ Sex: ____Male _____Female

Date of Birth: _____ Social Security Number: _____

Mailing address: _____

Home phone: _____Cell phone: _____Email:_____

Do you want to sign up for our patient portal? _____ Yes _____ No
A patient portal is a secure website for your personal health care information where you can track of your visits, test results, billing, and prescriptions.

How do you want us to remind you of your appointments? ____ Phone Call _____ Text _____Email

My pharmacy is:_____

In case of an emergency, whom do we contact?

Name:_____ Phone:_____ Relationship_____

Name:_____ Phone:_____ Relationship_____

Please provide us your insurance card and valid photo ID.

Do you have health insurance? ___Yes ____ No

If you have health insurance, which kind? ___ Private ____Medical Assistance (Medicaid)____ Medicare

Insurance Name: (example: Gateway, AmeriHealth, Blue Cross): _____

<u>Policy Holder's Place of Employment, Address, & Phone:</u>

Company: _____

Address/Phone: _____

Name of Insurance Company: _____

Policy #:_____ Group#:_____

Policy Holder Social Security #:_____ Policy Holder DOB: _____

Policy Holder Phone #:_____Address: _____

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Patient Name: _____ MRN_____

As a Federally Qualified Health Center, NHCLV is required by Federal Law to collect the following information for statistical purposes only. This is reported annually on a total patient basis. Individual patient information is NOT reported or disclosed. The collection of this information also assists NHCLV in applying for additional grant funds to support and expand its services. Thank you for your cooperation.

How many people, including yourself, live in your home? _____

Are you the head of the household? _____Yes_____ No

What is the total combined income of everyone living in your home? $_____ week / month / year

My primary language is: _____English _____Spanish _____Other Language (Specify): _____

Are you Hispanic/Latino? _____Yes _____ No Country of Origin: _____

My race is: (choose all that apply)

_____Asian	____Black / African-American	____ Native American
_____Native Hawaiian or Pacific Islander	____White/Caucasian	____ I choose not to tell
_____Other_____		

Please check the statement that best describes your housing situation:

____ I live in my home, which I/my family rent, lease, or own
____ I am staying with a series of friends and/or extended family members on a temporary basis.
____ I am staying in a supportive or transitional housing (such as a sober living facility or recovery home)
____ I live in a public or private facility that provides temporary shelters (such as a shelter, mission, single room occupancy facility, or motel)
____ I have been released from an institution (such as jail or hospital) without stable housing to return to
____ I live on the streets, in a car, park, sidewalk, in an abandoned building, or any unstable or non-permanent situation
____ I live in a foster care

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Patient Name: _____ MRN_____

If wish to apply for discounts for essential services (our sliding fee program), please complete the information below:

45-day Eligibility – I have received information identifying the documents necessary for my Sliding Fee Scale Application. I understand that I must return to the clinic with the missing documents as soon as possible. This eligibility is for 45 days only and expires on: _____.

Household Information		
Name	**Date of Birth**	**Social Security Number**

Household Income					
Name	**Amount**		**Frequency (Circle One)**		**Employer:**
You	**$**		Weekly Monthly Yearly		
Spouse/Partner	**$**		Weekly Monthly Yearly		
Children	**$**		Weekly Monthly Yearly		
Other	**$**		Weekly Monthly Yearly		
TOTAL	**$**		Weekly Monthly Yearly		
Other Income	**You**	**Spouse**	**Children**	**Other**	**Subtotal**
Social Security					
Public Assistance					
Retirement Pension					
Food Stamps					
Child Support, Alimony					
Interest Income					
Other					
				TOTAL	

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform NHCLV if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of NHCLV. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date: _____Name (Print):_____

Signature:_____

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Medical Information Communication Preferences

Patient: _____ DOB _____ MR# _____

As our patient, we may need to communicate with you when you are not available. To assure your privacy, we would like you to indicate your preferred method for us to communicate medical information to you and/or to others involved in your care. Please note that an "appointment reminder" is not classified as medical information.

PLEASE INDICATE YOUR COMMUNICATION PREFERENCES BELOW

_____I give permission to leave medical information pertaining to me, my dependent or child, at the number listed below:

Method	Yes	No	Area Code, Phone #, Extension
Home			
Answering Machine			
Work Phone			
Cell Phone			
E-mail			

Without specific permission, we will not release any medical information to anyone other than you. In some cases, you may wish for another person to have access to your medical information. Please identify those individuals and relationship to you (i.e. spouse, parent, son, daughter, partner, etc.):
****

_____Do not release medical information to anyone other than myself.

_____I give permission to release medical information pertaining to me to the individuals listed below:

Name	Relationship	Area Code, Phone #, Extension
Comments:		

I assume responsibility to inform NHCLV of changes in my phone number(s) or my preferences or to revoke this specific medical information authorization at any time.

_____

Signature Date

NHCLV Authorization to Provide Medical Care

Parental Authorization to Treat Minor Child When Not Accompanied by Parent or Legal Guardian

This authorization is for patients under 18 years of age. We must have permission from a Parent or Legal Guardian of the patient listed below, before providing medical services when someone accompanies the patient other than the Parent or Legal Guardian. If you (Parent /Legal Guardian) feel there may be an occasion when your child (patient) may be brought in by a relative, sitter, caretaker, etc., please fill out the following information for us to include in your child's records. This document constitutes your (Parent /Legal Guardian) authorization and consent to seek any and all medical care that NHCLV clinicians deem medically appropriate or necessary to your child (patient) – including, but not limited to vaccines. This authorization will be in effect from:

☐ Single Authorization for Date of: _____

☐ Yearly Authorization for Date range: _____ to _____

Patient's Name _____ DOB _____

Child's Allergies:_____

Child's Current Medication(s):_____

Child's Medical Condition(s):_____

Patient listed above may present and be treated accompanied by an adult listed below. The following person(s) have my (Parent/Legal Guardian) permission to authorize medical care for my child (patient) and sign any necessary waivers on my behalf.

Name	Relationship to Patient
1.	
2.	
3.	
4.	
5.	

_____ _____

Signature of Parent/Legal Guardian Date Parent/Legal Guardian Print Name Date

_____ _____

Witness 1 Signature Date Witness 1 Print Name Date

_____ _____

Witness 2 Signature Date Witness 2 Print Name Date

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Patient Name_____ **Age** _____ **MRN:**_____

Form completed by _____
Name and relationship to patient **Date**

Household

Name	Age	Relationship to child	Health Problems

Are there siblings not listed? If so, please list their names, ages & where they live. _____

What is the child's living situation if not with both biological parents? ___Lives with adoptive parents ____Joint custody ___Single custody ____Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent not in the home? _____

Birth History

Birth weight _____ Was the baby born term? ___ Early? ____ Late?___

What hospital was baby born at?_____ If early, how many weeks gestation? _____

Was the delivery □ vaginal □ C-section If C-section, why? _____

Did your baby have any problems right after birth? ___ Yes ___ No Explain: _____

Did baby pass hearing test at birth? ___ Yes ___ No Was initial feeding ___ bottle ___ breast, how long? _____

Did baby go home with mother from the hospital? ___ Yes ___ No Explain: _____

Did mother have any illness or problem with her pregnancy? ___ Yes ___ No Explain: _____

During pregnancy, did mother: Smoke ___ Yes ___ No Drink alcohol ___ Yes ___ No

Use drugs or medications ___ Yes ___ No What _____ When _____

General

Do you consider your child to be in good health? ___ Yes ___ No Explain _____

Does your child have any serious illness or medical condition? ___ Yes ___ No Explain _____

Has your child had serious injuries or accidents? ___ Yes ___ No Explain _____

Has your child had any surgery? ___ Yes ___ No Explain _____

Has your child ever been hospitalized? ___ Yes ___ No Explain _____

Is your child allergic to any medicines or drugs? ___ Yes ___ No Explain _____

Has your child had a reaction to immunizations? ___ Yes ___ No Explain _____

Where has your child gone for healthcare until now?_____ When was the last well child check-up?_____

_____

Development

Are you concerned about your child's physical development? ___ Yes ___ No Explain _____

Are your concerned about your child's mental/emotional development? ___ Yes ___ No Explain _____

Are you concerned about your child's attention span? ___ Yes ___ No Explain _____

If your child is in school: Have they failed or repeated a grade in school? ___ Yes ___ No Explain _____

How is his/her behavior in school?_____

How is he/she doing in academic subjects?_____

Does he/she have an IEP (individualized education plan)? ___ Yes ___ No Is he/she in special or resource classes? ___Yes ___No

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Patient Name_____**DOB** _____ **MRN:**_____

Past History Does your child have, or has he/she ever had:

Acne, eczema	___ Yes ___ No	When _____
(girls) Are there problems with periods?	___ Yes ___ No	When _____
(girls) Has she started menstrual periods?	___ Yes ___ No	When _____
Anemia or bleeding problem	___ Yes ___ No	When _____
Any chronic or recurrent skin problem	___ Yes ___ No	When _____
Any heart problem or heart murmur	___ Yes ___ No	When _____
Any other significant problem	___ Yes ___ No	When _____
Asthma	___ Yes ___ No	When _____
Bed-wetting (after 5 years old)	___ Yes ___ No	When _____
Bladder or kidney infection	___ Yes ___ No	When _____
Blood transfusion	___ Yes ___ No	When _____
Bronchitis, bronchiolitis, or pneumonia	___ Yes ___ No	When _____
Cancer	___ Yes ___ No	When _____
Chickenpox	___ Yes ___ No	When _____
Constipation requiring doctor visits	___ Yes ___ No	When _____
Convulsions or other neurologic problem	___ Yes ___ No	When _____
Diabetes	___ Yes ___ No	When _____
Frequent abdominal pain	___ Yes ___ No	When _____
Frequent ear infections	___ Yes ___ No	When _____
Frequent headaches	___ Yes ___ No	When _____
Nasal Allergies	___ Yes ___ No	When _____
Problems with ears or hearing	___ Yes ___ No	When _____
Problems with eyes or vision	___ Yes ___ No	When _____
Thyroid or other endocrine problem	___ Yes ___ No	When _____
Use of alcohol or drugs	___ Yes ___ No	When _____

Family History

Have any family members had the following:

Alcohol abuse	___ Yes ___ No	Who _____	Comments _____
Anemia	___ Yes ___ No	Who _____	Comments _____
Asthma	___ Yes ___ No	Who _____	Comments _____
Bed-wetting (after 10 years old)	___ Yes ___ No	Who _____	Comments _____
Bleeding Disorder	___ Yes ___ No	Who _____	Comments _____
Cancer	___ Yes ___ No	Who _____	Comments _____
Deafness	___ Yes ___ No	Who _____	Comments _____
Diabetes (before 50 years old)	___ Yes ___ No	Who _____	Comments _____
Epilepsy or convulsions	___ Yes ___ No	Who _____	Comments _____
Heart Disease (before 50 years old)	___ Yes ___ No	Who _____	Comments _____
Sudden cardiac death	___ Yes ___ No	Who _____	Comments _____
High blood pressure (before 50 years old)	___ Yes ___ No	Who _____	Comments _____
High Cholesterol	___ Yes ___ No	Who _____	Comments _____
Immune problems, HIV, or AIDS	___ Yes ___ No	Who _____	Comments _____
Kidney disease	___ Yes ___ No	Who _____	Comments _____
Liver disease	___ Yes ___ No	Who _____	Comments _____
Mental Illness	___ Yes ___ No	Who _____	Comments _____
Mental retardation	___ Yes ___ No	Who _____	Comments _____
Nasal Allergies	___ Yes ___ No	Who _____	Comments _____
Sudden cardiac death?	___ Yes ___ No	Who _____	Comments _____
Tuberculosis	___ Yes ___ No	Who _____	Comments _____

Additional family history_____

Thank you for taking the time to complete this form.