MATHIESEN MEMORIAL HEALTH CLINIC

"Close to home…far from ordinary"

Welcome to Mathiesen Memorial Health Clinic!

Mission: To improve the health and wellness of our community as the premier place to give and receive care that embraces the balance of mind, body, and spirit.

Vision: Established by the Chicken Ranch Rancheria of Me-Wuk Indians of California, Mathiesen Memorial Health Clinic is close to home, yet far from ordinary. We serve with kindness, integrity, compassion, collaboration, and strive for excellence to maximize individual and community health and wellness.

Locations:

Main Clinic

We take pride in having a happy, well-trained and courteous staff. These are just a few of the services we offer; please feel free to contact us with any medical concerns you may have.

Services: Routine Office Visits, Women's Health, Family Planning, Pediatric Care, Dermatology**, Hepatitis C Treatment**, Comprehensive Liver Care, Diabetic Treatment, Smoking Cessation Treatment, and lab draws & interpretation. (**referral required)

18144 Seco Street Jamestown, CA 95327 Phone: (209) 984-4820 Fax: (209) 984-4825

Red Feather Clinic

Serving our community to prevent and heal addiction. No referral needed, walk-ins welcome!

Services: Medication Assisted Treatment for Substance Use Disorder, Substance Use Disorder Counseling, Acupuncture Therapy, Pain Management**, Care Coordination, and NARCAN Available. (**referral required)

18232 Smoke Street Jamestown, CA 95327 Phone: (209)782-8625 Fax: (209)984-9240

Wellness Center

Our Wellness Center uses an integrative approach that helps patients to heal by taking the entire life experience into consideration.

Services: Individual, Family, and Child therapy, along with Therapeutic Yoga (virtual), Hypnosis, EMDR, Art therapy, and Psychological testing.

18158 Main St. Jamestown Ca 95327 Phone: (209)782-6446 Fax: (209)984-9169

Same Day Walk In Clinic

We provide treatment for illnesses and injuries that do not require a visit to the emergency room but need timely attention. Same day appointments available. Walk-in's welcomed!

Services: COVID testing/treatment site, Ear & Sinus Infections, Sports Physicals, Cough/Cold & Flu Symptoms, Urinary Tract Infections, Pink Eye, Rashes, Minor Sprains, STD Screening, and other non-life-threatening conditions or illnesses.

18268 Main St. Jamestown , CA 95327 Phone: (209)630-2772 Fax: (209)984-9085

Dental Clinic

Here to serve and support our community's dental needs. We offer services to all and accept Medi-Cal, Humana, out-of-network insurance, and offer a cash pay discount for the non-insured.

Services: Cleanings, Exams, Fillings, Simple Extractions, Root Canals, Crowns & Bridges, Dentures & Partials, and Digital X-rays & Impressions.

940 Sylva Lane #K2 Sonora, CA 95370 Phone: (209)536-8600 Fax: (209)536-8606

PATIENT: _____ DATE: _____

PATIENT HISTORY

1. What is your main complaint? _____
2. On the scale below, please circle the severity of your main complaint (At its worst)

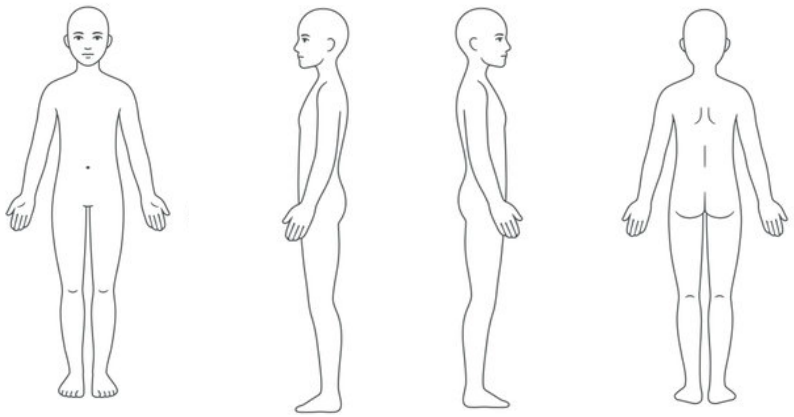
None		*Slight*		*Mild*					*Severe*
1	2	3	4	5	6	7	8	9	10

3. On the scale below, please circle the percentage of time you experience your main complaint:

		Occasional			*Intermittent*					*Constant*	
0	10	20	30	40	50	60	70	80	90	100	%

4. How long have you been experiencing your main complaint? _____
5. On the diagram below, please show where you are experiencing all your present complaints using the following letters:

A: ache B: burning Pain C: cramping D: Dull Pain R: Throbbing Pain N: numbness T: tingling



6. When do you notice it most? ☐ AM ☐ PM
   How long does it last? _____ Mins _____Hrs
7. What makes it feel better? _____
8. What makes it feel worse? _____
9. Have you ever had this problem in the past? ☐ Yes ☐ No
10. I have….
    ☐ Been hospitalized ☐ Been treated by another chiropractor
    ☐ Been treated by another specialty provider ☐ Never received care for this problem
11. Have you lost time from work because of it? ☐ Yes ☐ No
12. Are you pregnant? ☐ No ☐ Yes Due Date _____
13. What was the first day of your last menstrual cycle? _____
14. Number of pregnancies? _____ Miscarriages? _____

Do you have pain and/or difficulty performing any of the following activities: (Check)

Personal Care ☐
Lifting ☐
Reading ☐
Concentrating ☐
Work ☐
Driving ☐
Sleeping ☐
Recreation ☐
Walking ☐
Sitting ☐
Standing ☐
Social Life ☐

Signature: _____

Date: _____/_____/☐

Patient Name _____ Birthday_____ Primary Language_____ Gender M / F
Last First

Address _____City_____ State _____Zip _____Primary Phone_____

Employer _____Occupation_____ Other Phone_____

Subscriber Name _____Subscriber ID# _____Group #_____

Primary Health Plan _____Patient/Member ID # _____

Second Health Plan _____Primary Care Physician (PCP) _____ PCP Phone#_____

Are you under the care of a physician? ☐ No ☐ Yes, for what conditions? _____

How and when it began _____

Is this related to a specific work injury? _____

What treatment have you received for the above condition(s) ☐ Surgery ☐ Medications ☐ Physical Therapy
☐ Injections ☐ Chiropractic ☐ Therapeutic Massage ☐ Other _____

Describe your progress: ☐ Worse ☐ No Change ☐ 0 - 25% ☐ 26 - 50%
☐ 51 - 75% ☐ 76 – 100% Better

Circle your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back, Low Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other _____

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

In the past week, how much has your pain interfered with your daily activities?

No interference 0 1 2 3 4 5 6 7 8 9 10 unable to carry on activities

How often are your symptoms present? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Describe your current health overall: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

What are your goals for your acupuncture treatments? _____

How will you track your progress toward your goals? _____

☐ Alcohol/Drug Dependence
☐ Abnormal Menstruation
☐ Allergies
☐ Arthritis/Rheumatoid Arthritis
☐ Artificial Joints (list date and joint):
_____
☐ Asthma
☐ Blood disorder
☐ Breast lumps
☐ Cancer / Tumor (type and date):
_____
☐ Convulsions/Seizures
☐ Diabetes
☐ Diarrhea/Constipation
☐ Excessive Thirst
☐ Fainting or Dizziness
☐ Fatigue
Fever

☐ Frequent Urination
☐ Headache
☐ Heart Attack (date _____)
☐ Heartburn or Indigestion
☐ High Blood Pressure
☐ Hospitalizations (date and reason):
_____
☐ Surgeries (list date and type):
_____
☐ Kidney Disease
☐ Liver Problems
☐ Osteoporosis
☐ Pacemaker
☐ Palpitation/Arrhythmia
☐ Peptic Ulcer
☐ Pregnant, # weeks _____
If pregnant, are you under medical care? ☐ Yes ☐ No
☐ Prostate Problems

☐ Weight Gain/Loss
☐ Sinusitis
☐ Stroke (date_____)
☐ Tobacco Use – Type _____
☐ Frequency: _____ / Day
☐ Thyroid Disease
☐ Other _____
_____
☐ Medications_____
_____
If a family member has had any of the Following, please mark the appropriate Box and explain the relationship:
☐ Cancer _____
☐ Heart Disease_____
☐ Hypertension _____
☐ Lupus_____
☐ Other_____

Comments _____

I certify that the above information is complete and accurate to the best of my knowledge. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services. I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage. I understand that my practitioner of acupuncture services may need to contact my Primary Care Physician or treating physician if my condition needs to be co-managed. Therefore, I give authorization to my practitioner of acupuncture services to contact my medical doctor if necessary.

Patient Signature _____Date_____

MATHIESEN MEMORIAL HEALTH CLINIC

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Patient Information:

Patient Last Name: _____ First Name: _____ Middle: _____

Preferred Name: _____ Date of Birth: _____ Social Security # (SSN): _____

Preferred Language: _____ Tribal Affiliation: _____

Gender: ☐ M ☐ F ☐ M to F ☐ F to M ☐ other Race: _____ Marital Status: _____

Home Phone #: _____ Cell Phone #: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Minors Email Address: _____

Parents Email Address: _____

Mailing Address:

Address: _____ City: _____ State: _____ Zip: _____

Physical address (if different from mailing address*)*:

Address: _____ City: _____ State: _____ Zip: _____

Guarantor Information/Parent/Guardian (Complete ONLY if patient is a minor**):**

Mother/Guardian Name: _____ Relationship: _____

Date of Birth: _____ Phone #: _____ ID Number: _____

Father/Guardian Name: _____ Relationship: _____

Date of Birth: _____ Phone #: _____ ID Number: _____

☐ Please provide court documentation if guardianship is other than biologic mother/father on birth certificate.

Insurance Information:

Primary Insurance: _____ Policy ID #: _____

Name of Policy Holder: _____ DOB: _____ Group #: _____

Secondary Insurance: _____ Policy ID #: _____

Name of Policy Holder: _____ DOB: _____ Group #: _____

Prescription Coverage: _____ Policy ID #: _____

Name of Policy Holder: _____ DOB: _____ Group #: _____

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CONSENT TO TREAT

I, the undersigned, am requesting health care services from the personnel at Mathiesen Memorial Health Clinic. I consent to exams, tests, immunizations, and treatment deemed necessary for my health. I hereby authorize the release of any information, including diagnosis of medical condition, for the purpose of payment by my insurance carrier. I affirm that the statements are true and correct to the best of my knowledge. I authorize the release of any information required by my insurance company to process claims. I further authorize assignment of benefits directly to Mathiesen Memorial Health Clinic. I understand that in the event the insurance information is not complete and correct, or if my insurance fails to make payment, I will be financially responsible for services rendered.

_____ _____

Printed Name Date of Birth

_____ _____

Signature of Patient/Parent/Guardian Date

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NOTICE OF PRIVACY PRACTICE

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Mathiesen Memorial Health Clinic (MMHC). Our Notice of Privacy Practice provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practice is subject to change. If we change our notice, you may obtain a copy of the revised notice by asking for one at the clinic or contacting our Privacy Officer at 209-984-4827.

If you have any questions about our Notice of Privacy Practice, please contact:

Privacy Officer
P.O. Box 535
Jamestown, Ca 95327
Phone: 209-984-4827

I acknowledge receipt of the Notice of Privacy Practices of Mathiesen Memorial Health Clinic.

Patient Name: _____ Date of Birth: _____

Patient Signature : _____ Date : _____

MATHIESEN MEMORIAL HEALTH CLINIC

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PATIENT CONSENT FORM and INFORMATION FOR AI DICTATION

Patient Name: _____

Date of Birth: _____/_____/_____

INTRODUCTION

This form provides information about the use of artificial intelligence (AI) technology, its purposes, and the security measures in place to protect my privacy.

PURPOSE OF AI DICTATION

AI scribe dictation technology is utilized to convert spoken words into text format for the purpose of documenting medical information in an efficient and accurate manner. The AI system may be employed in the transcription of medical notes, reports, and other relevant documents.

HOW AI DICTATION WORKS

During my medical appointments, any verbal information provided by me or my healthcare provider may be recorded using AI scribe dictation. The AI system processes and transcribes spoken words into text, contributing to the creation of my medical records. The AI scribe will NOT be used to make any decisions about your care. Your doctor will review all the information in your medical record, including the AI-scribed notes, before making any decisions about your care.

SECURITY MEASURES

Mathiesen Memorial Health Clinic (MMHC) employs robust security measures to safeguard the confidentiality and integrity of the information processed through AI dictation. These measures include encryption, access controls, and regular security audits to prevent unauthorized access and protect against data breaches. All data recorded by the AI scribe will be deleted within 30 days and is not stored after that time.

PATIENT RIGHTS

1. Access to Information: I have the right to request access to my medical records and transcripts generated through AI dictation.

2. Amendment of Information: I have the right to request corrections or amendments to any inaccuracies in my medical records.

3. Withdrawal of Consent: I have the right to withdraw my consent for the use of AI dictation at any time. However, withdrawal may affect the efficiency of medical record documentation.

BENEFITS AND RISKS OF AI DICTATION

Benefits

• Increased efficiency in medical record documentation.

• Enhanced accuracy in transcribing verbal information.

Risks

• Possibility of errors in transcription.

• Potential limitations in recognizing certain accents, speech patterns or quiet speech.

PATIENT CONSENT

I have read and understand the information provided in this consent form. I have had the opportunity to ask questions and voice any concerns which have been addressed to my satisfaction. This consent will be in force until revoked by the patient.

By signing below, I voluntarily consent to the use of AI dictation technology in the creation of my medical records at MMHC.

Patient Signature: _____

Date: _____/_____/_____

If patient is a minor, name of parent/guardian: _____

Guardian Signature: _____

Date: _____/_____/_____

PATIENT DECLINATION

By signing below, I voluntarily **DECLINE** consent to the use of AI dictation technology in the creation of my medical records at MMHC.

Patient Signature: _____

Date: _____/_____/_____

If patient is a minor, name of parent/guardian: _____

Parent/Guardian Signature: _____

Date: _____/_____/_____

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Missed Appointment Policy

Patient Name: _____ Date of Birth:

Thank you for choosing Mathiesen Memorial Health Clinic (MMHC) as your health care provider. To ensure the highest quality of care for you and all our patients, we ask that you adhere to our guidelines concerning missed appointments. MMHC provides appointment reminders as a courtesy, but we kindly ask that you take responsibility for keeping or canceling it as needed. We require at least 24-hour notice to cancel or reschedule your appointment. This allows us to offer your cancelled appointment slot to another patient in need of care.

While MMHC strives to minimize missed appointments, we will allow up to three missed appointments in a six-month period. An appointment is considered missed under any of the following circumstances:

- Patient fails to show up to a scheduled appointment.
- Patient provides fewer than 24 hours' notice to cancel or reschedule an appointment.
- Patient who arrives more than 10 minutes past their scheduled appointment time.
  **For dermatology and same-day appointments, the grace period is reduced to 5 minutes*.
- Wellness Center:
  - New patient – grace period is 15 minutes
  - Established patients – grace period is 30 minutes

Patients who miss three of more consecutive appointments within a rolling six-month period may be dismissed from care at the clinic's discretion.

_____ _____

Signature Date

_____

Printed Name

Relationship to Patient (if applicable): _____

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PATIENT AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

Do you give our office permission to discuss your medical and/or financial information with a person(s)?

☒ Yes ☐ No (If yes, please provide additional information below)

Name	Relationship	Phone Number

Please select authorized clinics:	Information authorized to discuss:
☐ Primary Care, Dermatology, Walk-In Clinic, and Dental ☐ Acupuncture, Red Feather Clinic, and Behavioral Health ☐ Other- Please Specify:	☐ Appointment Scheduling ☐ Treatment Details ☐ Lab and Test Results ☐ Insurance and Billing Information ☐ All Medical and Financial Information

This authorization will expire six months from the date signed, unless an alternate expiration date is noted here: _____

Name	Relationship	Phone Number

Please select authorized clinics:	Information authorized to discuss:
☐ Primary Care, Dermatology, Walk-In Clinic, and Dental ☐ Acupuncture, Red Feather Clinic, and Behavioral Health ☐ Other- Please Specify:	☐ Appointment Scheduling ☐ Treatment Details ☐ Lab and Test Results ☐ Insurance and Billing Information ☐ All Medical and Financial Information

This authorization will expire six months from the date signed, unless an alternate expiration date is noted here: _____

May we leave personal medical information on your answering machine, voicemail, email, or text message: ☐ Yes ☒ No

Patient Name: _____ Date of Birth:

Patient Signature: _____ Date:

Inability to obtain acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why it was not obtained. Patient reason for refusing or inability to sign acknowledgement:

_____

Staff Use- Clinic accepting Patient Authorization form:

☐ Primary Care
☐ Dental Clinic
☐ Walk-In Clinic
☐ Red Feather Clinic
☐ Wellness Center
☐ Acupuncture

Patient Label