



Ampla Health strives to provide high-quality medical, dental, social, and educational health services that meet the unique needs of all patients, especially those who are medically underserved, including farm workers and others without financial resources.

Medical, Dental, Mental Health, and Specialty Services Patient Information

Serving the Community Since 1964

About Ampla Health

Ampla Health is a 501(c) 3 non-profit network of community-based Federally Qualified Health Centers (FQHC) offering comprehensive medical, dental, mental health, and specialty health care services in Butte, Colusa, Glenn, Sutter, Tehama and Yuba counties.

Ampla Health has thirteen medical and six dental centers conveniently located throughout Northern California to provide you and your family greater access to your health care needs.

Ampla Health was founded in 1964 to serve seasonal and migrant farm workers and low-income populations.

Ampla Health provides confidential services and protects patient's privacy. We accept Medi-Cal, Medicare, and most private health insurances. If you are uninsured and your income is low, you may qualify for our sliding-fee scale discount plan program.

Ampla Health continually strives to be the communities' health care provider and employer of choice that serves Northern California.

Ampla Health encourages patients to take an active role in their health care needs by participating in prevention, wellness, and chronic care programs that can assist with healthier lifestyles. We also recommend patients to select a primary care provider of choice to help them access the best care available. We are passionate about helping people live healthier lives and believe each patient benefits by receiving high-quality medical, dental, social, and educational health services.

Ampla Health History

Ampla Health is a network of migrant and community health centers serving farm workers and other low-income populations. Serving six counties (Butte, Colusa, Glenn, Sutter, Tehama and Yuba counties), we provide comprehensive primary medical, dental, mental health and specialty care to an ethnically diverse population, including migrant and seasonal farm workers with 13 medical and 6 dental centers.

Ampla Health originated in 1964, in the form of a medical care project for migrant farm workers under the State Farm Workers Health Service and Migrant Health Act Fund. The original organization was known as the Sutter-Yuba Farm Workers Health Project, and the County of Sutter was grantee for the funds. It was operated as a night clinic in the Sutter County General Hospital.

In the Spring of 1973, the Consumer Advisory Board incorporated as a non-profit organization, at the suggestion of the Department of Health, Education, and Welfare, to become Northern Sacramento Valley Rural Health Project, Inc. Under this corporation status the agency became a grantee for the 1973-74 Migrant Health Act Funds and continued to provide quality health care services. As a result of additional funding, an Executive Director was hired and the direct client service deliverables expanded to include Butte, Colusa, and Glenn Counties.

In June 2011, the corporate name changed to Ampla Health. Ampla Health continues to be a proactive community partner while focusing on the individual needs of each community.

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Board of Directors

Ampla Health is a 501(c) 3 non-profit Federally Qualified Health Center (FQHC) governed by a volunteer Board of Directors in compliance with requirements set forth by 330 grants and by the agency's by-laws. The board must include a majority (at least 51%) of active, registered clients of the health center who are representative of the populations served by the center. The governing board ensures the organization is community-based and responsive to the community's health care needs. Under certain conditions the board composition requirements may only be waived for migrant, homeless, and public housing health centers.



Executive Team



Benjamin H. Flores, MPH

President & CEO

Benjamin H. Flores, MPH is President and Chief Executive Officer of Ampla Health, headquartered in Yuba City, California. Ampla Health, a Federally Qualified Health Center with 13 medical and 6 dental centers in Butte, Colusa, Glenn, Tehama, Sutter and Yuba Counties; it serves more than 70,000 members in Northern California. Mr. Flores was named to this position in April 2009.

James Tesar, MBA
Chief Financial Officer

Mustafa Ammar, MD
Chief Medical Officer

Cindy Snelgrove, MSN, MBA
Director of Clinical Services

Hilton T. Perez, MD, MBA
Chief Operations Officer

Daniel Siri, DDS
Chief Dental Officer

Coreena Conley, MBA
Director of Planning & Development

Services

Medical and Pediatric Services

Family Medicine
Internal Medicine
Pediatrics
Primary Care

Dental Services

Check ups
Common Dental Issues
Crowns and Bridges
Dentures
Fillings
Gum Disease (Periodontics)
Oral Surgery
Root Canals

Mental Health Services

Anxiety
Attention Deficit Disorder
Bipolar Disorder
Counseling
Medication Management

Specialty Services

Anticoagulation Services
Comprehensive AIDS Resources Emergency
(CARE) Project
Comprehensive Primary Care for HIV/AIDS
Nutrition Program
Perinatal Care Program
Telehealth Program
Women, Infants and Children (WIC) Program

Locations

Ampla Health Arbuckle Medical and Dental

89 Putnam Way, Arbuckle, CA 95912
Medical: (530) 476-2200
Monday & Wednesday: 8am-5pm
Tuesday & Thursday: 10am-7pm
Closed Fridays
Dental: (530) 476-2241
Monday, Wednesday, Friday: 8:00am-5:00pm

Ampla Health Chico Medical and Pediatrics

680 Cohasset Road, Chico, CA 95926
Medical: (530) 342-4395
Monday-Friday: 8:00am-5:00pm
Saturday: 8:00am-5:00pm
Pediatrics: (530) 342-4395
Monday-Friday: 8:00am-5:00pm

Ampla Health Chico Dental

236 W East Ave., Suite H, Chico, CA 95926
Dental: (530) 342-6065
Monday-Friday: 7:15am-7:00pm

Ampla Health Colusa Medical and Dental

555 Fremont Street, Colusa, CA 95932
Medical: (530) 458-8635
Monday-Friday: 8:00am-5:00pm
Dental: (530) 458-5165
Tuesday & Thursday: 8:00am-5:00pm

Ampla Health Gridley Medical

520 Kentucky Street, Gridley, CA 95948
Medical: (530) 846-6231
Monday, Wednesday & Friday:
8:00am-5:00pm
Tuesday & Thursday: 8:00am-7:00pm

Ampla Health Hamilton City Medical

231 Main Street, Hamilton City, CA 95951
Medical: (530) 826-3694
Monday-Friday: 8:00am-5:00pm
(Closed: 1:00pm-2:00pm)

Ampla Health Lindhurst Medical and Dental

4941 Olivehurst Avenue
Olivehurst, CA 95961
Medical: (530) 743-4611
Monday-Friday: 8:00am-5:00pm
Saturday: 8:00am-4:30pm
(Closed: 12:30pm-1:00pm)
Dental: (530) 743-4614
Monday-Friday: 7:00am-4:00pm
Saturday: 7:00am-4:00pm
(Closed: 12:30pm-1:00pm)

Ampla Health Los Molinos Medical

7883 HWY 99 East, Los Molinos, CA 96055
Medical: (530) 384-2372
Monday-Thursday 8:30am-5:30pm

Ampla Health Orland Medical and Dental

1211 Cortina Drive, Orland, CA 95963
Medical: (530) 865-5544
Monday-Wednesday,
Friday: 8:00am-5:00pm
Thursday: 8:00am-7:00pm
Dental: (530) 865-5561
Monday-Wednesday,
Friday: 7:15am-4:15pm
Thursday: 8:00am-7:00pm

Ampla Health Oroville Medical and Dental

2800 Lincoln Street, Oroville, CA 95966
Medical: (530) 534-7500
Monday-Friday: 8:00am-5:30pm
Saturday: 8:00am-5:00pm
Dental: (530) 533-6484
Monday-Friday: 7:15am-4:15pm

Ampla Health Richland Medical

334 Samuel Drive, Yuba City, CA 95991
Medical: (530) 674-9200
Monday & Thursday: 8:00am-7:00pm
Tuesday, Wednesday, &
Friday: 8:00am-5:00pm
Saturday: 9:00am-5:00pm

Ampla Health Yuba City Medical

1000 Sutter Street, Yuba City, CA 95991
Medical: (530) 673-9420
Monday-Friday: 8:00am-7:00pm
Saturday: 8:00am-5:00pm

Ampla Health Yuba City Pediatrics

931 Market Street, Yuba City, CA 95991
Pediatrics: (530) 671-8820
Monday-Friday: 8:30am-5:30pm

Patient Information

Registration

If you are a new patient, you should arrive at least 30 minutes before your first appointment to register. If you are applying for the sliding fee discount, you should bring recent pay stubs, income tax returns or social security income verification; a utility bill; and picture identification. Also, bring any health insurance cards. For more information, call any of our clinics. A custodial parent or guardian must sign the medical consent form prior to any treatment of a minor child. Parents should bring children's immunization (shot) records each time they come to the clinic.

Appointments

It is necessary that we work by appointments. When calling for an appointment, be prepared to tell the receptionist the nature of your visit so she can allow adequate time for you with the provider. Patients who arrive without appointments will be worked-in whenever necessary. If your provider wants you to return to the office in the near future, please make your appointment before leaving the office. It is our goal to schedule patients in a timely manner.

Missed Appointments

Keep your appointment! If you cannot keep your appointment, call at least 24 hours in advance to cancel.

Your Medical Record

To best serve you, please make sure that we have your current name, address and phone number in your record. Notify us immediately of any change

in this information. Your records are confidential documents. If you wish to release any information in your records to another party, such as an insurance company or another provider, you must sign a form authorizing the release of this information.

Fees

Ampla Health is unique, in that we offer discounts on our fees based upon your ability to pay. To qualify for the sliding fee scale, you will need to bring in specific documents. Please request the receptionist to provide information regarding the sliding fee scale. Ampla Health requires payment of fees at the time of the visit. Billing for services is permitted only after you have arranged a payment plan. The business office at each clinic will be glad to answer any questions you may have about our fees.

Telephone Calls

Telephone calls are routinely handled by our medical and dental personnel who will usually be able to answer your questions. If you need to speak with your doctor, you may be asked to leave a message for the doctor to return your call. After clinic operation hours, call the number listed for your clinic.

Lab and X-Ray Fees

For your convenience, laboratory specimens may be taken in the clinic and sent to a laboratory for analysis. Some tests can be analyzed in the clinic. Your provider reviews all laboratory and X-ray results.

Patient Information

Prescription/Refills

Prescription refill requests should be made to your pharmacy. Please allow a minimum of 24 hours for refills. Patients on our sliding fee scale may be eligible to receive prescriptions at a discounted fee. Prescription renewals require an appointment.

Insurance

Ampla Health accepts most insurance plans. We will bill your insurance company as a courtesy; however, you are responsible to pay, immediately, any deductible amount, or co-payment that the insurance company does not pay. If, after Ampla Health receives payment from your insurance and there is still a balance in your account, you are responsible for paying this balance. Ampla Health accepts Medi-Cal, Medicare, private insurance, private pay, sliding fee

scale discount, Workers Compensation, Family Planning, and CHDP. **Please bring your insurance card and any other information regarding your benefits to the clinic with you to each appointment.**

Patient Advocate

Should you have a complaint, please attempt to resolve it with the site administrator. Should you remain dissatisfied with the outcome, please refer the matter to our patient advocate: **(866) 358-9791 or (530) 751-3710.**

Languages Translation Services

Ampla Health offers language translation services upon request.



Clinic Contacts

Please feel free to call the site administrator if a situation arises that you have questions or concerns about. The site administrator will work with you.

| | | |
|---|---------------------|----------------|
| Ampla Arbuckle Medical and Dental Site Administrator | Jennifer Huff | (530) 476-2200 |
| Ampla Chico Medical and Pediatrics Site Administrator | Amalia Bejarano | (530) 342-4395 |
| Ampla Chico Dental Site Administrator | Susie Dolan | (530) 342-6065 |
| Ampla Colusa Medical Site Administrator | Jennifer Huff | (530) 458-8635 |
| Ampla Gridley Medical Site Administrator | Jennifer Huff | (530) 846-6231 |
| Ampla Hamilton City Medical Site Administrator | Alex Martinez | (530) 826-3694 |
| Ampla Lindhurst Medical and Dental Site Administrator | Stephanie Donaldson | (530) 743-4611 |
| Ampla Los Molinos Medical Site Administrator | TBA | (530) 384-2372 |
| Ampla Orland Medical and Dental Site Administrator | Alex Martinez | (530) 865-5544 |
| Ampla Oroville Medical and Dental Site Administrator | Susie Dolan | (530) 534-7500 |
| Ampla Richland Medical Site Administrator | Irene Harden | (530) 674-9200 |
| Ampla Yuba City Medical Site Administrator | Lourdes Guzman | (530) 673-9420 |
| Ampla Yuba City Pediatric Site Administrator | Irene Harden | (530) 671-8820 |

Patient Rights and Responsibilities

Patient Rights and Responsibilities

Ampla Health is committed to providing high-quality, cost-effective health care to the people we serve. We believe that every patient deserves to be treated with respect, dignity, and concern. We will provide care regardless of race, creed, sex, national origin, or source of payment.

We consider you a partner in your health care. When you are well informed, participate in treatment decisions, and communicate openly with your doctor and other health professionals, you help make your care as effective as possible. Ampla Health encourages respect for the personal preferences and values of each individual. It is our goal to assure that your rights as a patient are observed and to act as a partner in your decision making process.

While you are a patient at Ampla Health, you have the following rights:

➤ Access to Care

- To exercise these rights without regard to gender, sexual orientation, culture, economics, education, religion, language, age, race, color, ancestry, national origin, presence of a disability, or the source of payment for your care.
- To obtain a reasonable response to any reasonable request made for services within the Health Center's capacity, stated mission, applicable laws, and regulations. The health center will give each patient necessary health services to the best of its ability.
- To appropriate access to emergency services.

➤ Considerate and Respectful Care

- To considerate, respectful care and treatment that optimizes your comfort and dignity.
- To appropriate care which reflects your desires, or that of a legal representative (surrogate decision maker), while acknowledging physical limitations, psychosocial, spiritual, and cultural concerns.
- To reasonable continuity of care and knowledge in advance of the time and location of future appointments, as well as the identity of the persons providing that care.

➤ Knowledge and Information

- To have knowledge of the name of the doctor who has primary responsibility for coordinating your care and the names and professional relationships of other health professionals who will see you.
- To receive information from the doctor about your care and treatment in terms that you can understand.
- To receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse this course of treatment.
- To have the right to choose your primary health care provider.

➤ Active Participation in Their Care

- To actively participate with your doctor in making decisions regarding your care. Your designated representative also has this right.
- To formulate advance directives.

➤ Privacy and Confidentiality

- To full consideration of privacy concerning your care and treatment. Your visit, discussion, consultation, examination and treatment are confidential and will be conducted discreetly.
- To confidential treatment of all information, communications, and records pertaining to your care and treatment. Written permission from you or your legally designated representative shall be obtained before medical records can be made available to anyone not directly concerned with patient care. You or your legally designated representatives are entitled to access the information contained in your medical record, within the limits of the law.

➤ Respect for Patient Rights

- To express concerns or complaints about your care with the assurance that the presentation of a complaint will not compromise the quality of your care or future access to care and to expect a reasonable and timely response to your concerns. The patient advocate number is (866) 358-9791.
- To expect that all Ampla Health personnel shall observe these patient rights and that all patient rights apply to the person who may have legal responsibility to make decisions regarding medical care on your behalf.
- To receive information about Advanced Directives.

➤ Patient Responsibilities

- While you are a patient at Ampla Health, you have the responsibility to:
- Provide your doctor with accurate and complete health information including all prescription and over-the-counter medications you are taking.
- Let your doctor know that you understand the medical procedures and what you are expected to do.
- Be considerate and respectful of others, both patients and staff.
- If you do not follow your doctor's plan or if you refuse treatment, you must accept responsibility for your actions.
- Be responsible for assuring that the financial obligations of your care are fulfilled as promptly as possible.
- Be responsible for following health care facility rules and regulations affecting patient care and conduct.

HIPAA Notice of Privacy Practices

WHO WILL FOLLOW THIS NOTICE

This notice describes information about privacy practices followed by our staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider. This notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.



Mustafa Ammar, M.D.
CHIEF MEDICAL OFFICER

This notice describes information about privacy practices followed by office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider. This notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We must have your written, signed Consent to use and disclose health information for the following purposes:

For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to our pharmacy, scheduling lab work, and ordering X-rays. Family members and other health

care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment: We may use and disclose health information about you so that the treatment and services you receive at this health center may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health care Operations: We may use and disclose health information about you in order to run the health center and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders: We may contact you as a reminder that you have an appointment for treatment or medical care at the office. We may leave a message on your answer machine or on voicemail as a means of communication. We may mail you a post card or written notice as a means of communication. We may also notify you via email or the patient portal.

Treatment Alternatives: We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services: We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

You may revoke your consent at any time by

HIPAA Notice of Privacy Practices

giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures that occurred before that time.

If you do revoke your consent, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operations, and we may, therefore, choose to discontinue providing you with health care treatment and services.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law: We will disclose health information about you when required to do so by federal, state, or local law.

Research: We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation: If you are an organ donor, we may release health information to organizations that handle organ procurement or organ; eye or tissue transplantation; or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security, and Intelligence: If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medication, or problems with products.

Health Oversight Activities: We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement: We may release health information, if asked to do so by a law enforcement official, in response to a court order, subpoena, warrant, summons, or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners, and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends: We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed. In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the people who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. We must obtain your *Authorization* separate from any consent we may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

Notice of Privacy Practices

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written Authorization (different than the Authorization and Consent mentioned previously) from you. In order to disclose these types of records for purposes of treatment, payment, or health care operations; we will have to have both your signed Consent and a special written Authorization that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our Compliance and Quality Improvement Officer in order to inspect and /or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other associated supplies. We may deny your request to inspect and / or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend: If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. To request an amendment, complete and submit a Medical Record Amendment/Correction Request Form to our Compliance and Quality Improvement Officer.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, and health care operations. To obtain this list, you must submit your request in writing to our Compliance and Quality Improvement Officer. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list for example, on paper or electronically. We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care

operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not required to Agree to Your Request: If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit the Request For Restriction On Use/Disclosure Of Medical Information to our Compliance and Quality Improvement Officer.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work, by mail or by email.

To request confidential communications, you may complete and submit the Request For Restriction On Use/Disclosure Of Medical Information and/or Confidential Communication to our Compliance and Quality Improvement Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact our Compliance and Quality Improvement Officer.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of this notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201. To file a complaint with our office, contact our Compliance and Quality Improvement Officer at 935 Market Street, Yuba City, CA 95991. You will not be penalized for filing a complaint.

Adult Medi-Cal Dental Services

What you need to know

Many dental services for Adult Medi-Cal recipients are still available for patients 21 years of age and over.

These dental services are mainly for relief of pain and infection.

Until future clarification by the State of California, these dental services include but are not limited to the following:

- Extraction of teeth
- Smoothing of broken teeth that are cutting cheeks or tongue.
- Placement of sedative or temporary fillings in sensitive teeth.
- Office visit for dental infections and pain.

- Evaluations of suspicious lesions [spots] in the mouth.
- Reducing sensitivity in teeth.
- Treatment of many conditions for pregnant women, primarily preventive and gum disease related issues.
- Full range of treatment for patients residing in nursing homes and skilled nursing facilities.

Sliding Fee Scale Discounts are available for:

- Non-covered Medi-Cal services
- Uninsured/Underinsured

(*Based on income eligibility)

Dental Service Locations

Ampla Health Arbuckle Dental

89 Putnam Way, Arbuckle, CA 95912

Direct: (530) 476-2241

Monday, Wednesday, Friday: 8:00am-5:00pm

Ampla Health Chico Dental

236 W East Ave., Suite H, Chico, CA 95926

Direct: (530) 342-6065

Monday–Friday: 7:15am-7:00pm

Ampla Health Colusa Dental

555 Fremont Street, Colusa, CA 95932

Direct: (530) 458-5165

Tuesday & Thursday: 8:00am-5:00pm

Ampla Health Lindhurst Dental

4941 Olivehurst Avenue, Olivehurst, CA 95961

Direct: (530) 743-4614

Monday–Friday: 7:00am-4:00pm

Saturday: 7:00am-4:00pm

(Closed 12:30pm-1:00pm)

Ampla Health Orland Dental

1211 Cortina Drive, Orland, CA 95963

Direct: (530) 865-5561

Monday–Wednesday, Friday: 7:15am-4:15pm

Thursday: 8:00am-7:00pm

Ampla Health Oroville Dental

2800 Lincoln Street, Oroville, CA 95966

Direct: (530) 533-6484

Monday–Friday: 7:15am-4:15pm



Advance Health Care Directive Form Instructions

You have the right to give instructions about your own health care.

You also have the right to name someone else to make health care decisions for you.

The Advance Health Care Directive form lets you do one or both of these things. It also lets you write down your wishes about donation of organs and the selection of your primary physician. If you use the form, you may complete or change any part of it or all of it. You are free to use a different form.

Part 1: Power of Attorney

Part 1 lets you:

- **name** another person as **agent** to make health care decisions for you if you are unable to make your own decisions. You can also have your agent make decisions for you right away, even if you are still able to make your own decisions.
- also **name an alternate agent** to act for you if your first choice is not willing, able, or reasonably available to make decisions for you.

Your **agent** may not be:

- an operator or employee of a community care facility or a residential care facility where you are receiving care.
- your supervising health care provider (the doctor managing your care)
- an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Your **agent** may make all health care decisions for you, unless you limit the authority of your agent. You do not need to limit the authority of your agent.

If you want to limit the authority of your agent the form includes a place where you can limit the authority of your agent.

If you choose not to limit the authority of your agent, your agent will have the right to:

- Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
- Choose or discharge health care providers (i.e. choose a doctor for you) and institutions.
- Agree or disagree to diagnostic tests, surgical procedures, and medication plans.

- Agree or disagree with providing, withholding, or withdrawal of artificial feeding and fluids and all other forms of health care, including cardiopulmonary resuscitation (CPR).

- After your death make anatomical gifts (donate organs/tissues), authorize an autopsy, and make decisions about what will be done with your body.

Part 2: Instructions for Health Care

You can give specific instructions about any aspect of your health care, whether or not you appoint an agent.

There are choices provided on the form to help you write down your wishes regarding providing, withholding or withdrawal of treatment to keep you alive.

You can also add to the choices you have made or write out any additional wishes. You do not need to fill out part 2 of this form if you want to allow your agent to make any decisions about your health care that he/she believes are best for you without adding your specific instructions.

Part 3: Donation of Organs

You can write down your wishes about donating your bodily organs and tissues following your death.

Part 4: Primary Physician

You can select a physician to have primary or main responsibility for your health care.

Part 5: Signature and Witnesses

After completing the form, **sign and date it** in the section provided.

The form must be signed by **two qualified witnesses** (see the statements of the witnesses included in the form) **or** acknowledged before a notary public. **A notary is not required if the form is signed by two witnesses. The witnesses must sign the form on the same date it is signed by the person making the Advance Directive.**

See part 6 of the form if you are a patient in a skilled nursing facility.

Part 6: Special Witness Requirement

A Patient Advocate or Ombudsman must witness the form **if you are a patient in a skilled nursing facility** (a health care facility that provides skilled nursing care and supportive care to patients). See Part 6 of the form.

You have the right to change or revoke your Advance Health Care Directive at any time.

Advance Health Care Directive

Name _____ Date _____

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form also lets you write down your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or change all or any part of it. You are free to use a different form.

You have the right to change or revoke this advance health care directive at any time.

Part 1 — Power of Attorney for Health Care

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

Name of individual you choose as agent: _____

Relationship _____

Address: _____

Telephone numbers: (Indicate home, work, cell) _____

ALTERNATE AGENT (Optional): If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Name of individual you choose as alternate agent: _____

Relationship _____

Address: _____

Telephone numbers: (Indicate home, work, cell) _____

SECOND ALTERNATE AGENT (optional): If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Name of individual you choose as second alternate agent: _____

Address: _____

Telephone numbers: (Indicate home, work, cell) _____

(1.2) AGENT'S AUTHORITY: My agent is authorized to 1) make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive; 2) to choose a particular physician or health care facility; and 3) to receive or consent to the release of medical information and records, except as I state here:

(Add additional sheets if needed.)

(1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I initial the following line.

If I initial this line, my agent's authority to make health care decisions for me takes effect immediately.
____ (initial here)

(1.4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) AGENT'S POST DEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

(Add additional sheets if needed.)

(1.6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named. _____ (initial here)

Part 2 — Instructions for Health Care

If you fill out this part of the form, you may strike out any wording you do not want.

(2.1) END-OF-LIFE DECISIONS: I direct my health care providers and others involved in my care to provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

a) Choice Not To Prolong

I do not want my life to be prolonged if the likely risks and burdens of treatment would outweigh the expected benefits, or if I become unconscious; and, to a realistic degree of medical certainty, I will not regain consciousness, or if I have an incurable and irreversible condition that will result in my death in a relatively short time.

Or

b) Choice to Prolong

I want my life to be prolonged as long as possible within the limits of generally accepted medical treatment standards.

(2.2) OTHER WISHES: If you have different or more specific instructions other than those marked above, such as: what you consider a reasonable quality of life, treatments you would consider burdensome) or unacceptable, write them here.

(Add additional sheets if needed.)

Part 3 — Donation of Organs at Death (Optional)

(3.1) Upon my death (mark applicable box):

- I give any needed organs, tissues, or parts
- I give the following organs, tissues or parts only: _____
- I do not wish to donate organs, tissues or parts.

My gift is for the following purposes (strike out any of the following you do not want):

Transplant Therapy Research Education

Part 4 — Primary Physician (Optional)

(4.1) I designate the following physician as my primary physician:

Name of Physician: _____

Address: _____

Telephone: _____

Part 5 — Signature

(5.1) EFFECT OF A COPY: A copy of this form has the same effect as the original.

(5.2) SIGNATURE: Sign name: _____ Date: _____

(5.3) STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual’s identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this advance directive in my presence (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual’s health care provider, an employee of the individual’s health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

WITNESS 1 INITIAL WITNESS 2 INITIAL

FIRSTWITNESS

Print Name: _____

Address: _____

Signature of Witness: _____ Date: _____

SECOND WITNESS

Print Name: _____

Address: _____

Signature of Witness: _____ Date: _____

(5.4) ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration: I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual’s estate on his or her death under a Will now existing or by operation of law.

Signature of Witness: _____

Signature of Witness: _____

Part 6 — Special Witness Requirement if in a Skilled Nursing Facility

(6.1) The patient advocate or ombudsman must sign the following statement: STATEMENT OF PATIENT ADVOCATE OF OMBUDSMAN I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by section 4675 of the Probate Code:

Print Name: _____ Signature: _____

Address: _____ Date: _____

Certificate of Acknowledgement of Notary Public (Not required if signed by two witnesses)

State of California

County of _____)

On _____ before me, _____
(insert name and title of the officer)

personally appeared _____,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Seal)



Administrative Operations
 Business Policies and Procedures
LOG FOR MEDICAL RECORDS

I acknowledge that I have received a copy of the Notice of Privacy Practices, Patient Rights, and Advanced Directives. I have been informed that I have a right to select a personal clinician for my health care. I understand the selection of my clinician and support team is important for the quality of care and continuity of service that I receive.

Clinicians Name: _____

 Signature

 Date

| Date | Agency and Location | Ampla Health Staff Signature | Medical Records | |
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Patient Name _____ Date _____

***Please see requesting agency's authorization for list of information sent**



REGISTRO DE OPERACIONES ADMINISTRATIVAS

**Reglamentos y Procedimientos Administrativos para los Registros Médicos
Formulario de Archivos Médicos**

Reconozco que he recibido una copia del aviso de las prácticas de privacidad y los derechos del paciente. He sido informado de que tengo el derecho a seleccionar a un proveedor médico para mi cuidado de salud. Entiendo que la selección de mi Médico y su equipo de apoyo es importante para mantener la calidad de la atención y continuidad del servicio que recibo.

Nombre del Médico: _____.

_____ Firma

_____ Fecha

| Fecha | Agencia | Empleado | Archivos Médicos | |
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Nombre _____ Date _____

* Favor de observar la lista de información sometida a la agencia requerida



Administrative Operations
Business Policies and Procedures
LOG FOR DENTAL RECORDS

I acknowledge that I have received a copy of the Notice of Privacy Practices and Patient Rights. I have been informed that I have a right to select a personal clinician for my dental care. I understand the selection of my dentist and support team is important for the quality of care and continuity of service that I receive. **Clinicians Name:**_____.

_____ Signature

_____ Date

| Date | Agency and Location | Ampla Health Staff Signature | Dental Records | |
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Patient Name_____ **Date**_____

*Please see requesting agency’s authorization for list of information sent



REGISTRO DE OPERACIONES ADMINISTRATIVAS
Reglamentos y Procedimientos Administrativos para los Registros Dentales
Formulario de Archivos Dentales

Reconozco que he recibido una copia del aviso de las prácticas de privacidad y los derechos del paciente. He sido informado de que tengo el derecho a seleccionar a un proveedor dental para mi cuidado dental. Entiendo que la selección de mi Dentista y su equipo de apoyo es importante para mantener la calidad de la atención y continuidad del servicio que recibo.

Nombre del Dentista: _____.

Firma
Fecha

| Fecha | Agencia | Empleado | Archivos Dentales | |
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Nombre _____ Fecha _____

* Favor de observar la lista de información sometida a la agencia requerida

Tobacco/Smoke Free Environment

Effective February 14, 2013

Ampla Health is a tobacco/smoke free environment. This policy applies to all tobacco products including but not limited to, cigarettes, cigars, pipes, herbal tobacco products, and chewing tobacco.

The purpose of the policy is to reduce harm from the use of tobacco products, secondhand smoke, thus providing an environment that encourages individuals to be smoke-free and to establish a campus culture of wellness.

Ampla Health is committed to enhancing the health and well-being of the people in the communities it serves by promoting affordable quality health care and the prevention of disease.

To maintain healthy surroundings all Ampla Health properties, parking lots, rented facilities and vehicles shall adhere to a tobacco/smoke free environment.

Another reason why Ampla Health is leading the way!



For additional information visit:
www.amplahealth.org/tobaccofree
or Call 1(800) NOBUTTS
1 (800) 662-8887

Coming Soon

We're here for you.
Wherever you are.
Online and on your smartphone.



You will be able to save time and enjoy the convenience of communicating with us anytime, anywhere.

Accomplish the following tasks right from your computer or smartphone:

- | | | |
|--|--------|---------------------|
| ✓ Request appointments | online | on your smart phone |
| ✓ Renew prescriptions | online | on your smart phone |
| ✓ Receive lab results and office updates | online | |
| ✓ Make payments | online | on your smart phone |
| ✓ Complete paperwork | online | |
| ✓ Submit non-urgent health questions | online | on your smart phone |
| ✓ View and reply to secure messages | online | on your smartphone |

Connect with us today at

www.amplahealth.org