SHINGLETOWN
MEDICAL CENTER
a california health+ center

(530) 474-3390
ShingletownMedCenter.org
31292 Alpine Meadows Road
Shingletown, CA 96088

Dear New Patient,

Thank you so much for choosing Shingletown Medical Center for your primary health care!

Although we make every effort to schedule appointments as soon as possible, new patients require more attention on their first visit than established patients. And, because we use an Electronic Medical Records system, your first visit will proceed much more smoothly if we can record this information in advance of your appointment. Attached you will find our "Patient Information Form" which must be completed and returned to us prior to your visit. Along with it, please return a completed "Release of Information" form if you have recently received medical care elsewhere. In fact, by sending this back to us early, you will make it possible to have your medical history in a permanent record and available to your provider before you even walk in the door!

If you are unable to return these forms about one week ahead of time, please plan to arrive at least thirty minutes before your scheduled appointment with completed forms. This will allow staff to input your information beforn you see your provider.

Should you need assistance filling it out, please plan to arrive at least an hour early, and someone on staff will help you.

On your first visit, please bring the following: your current insurance card; and all of your current prescription bottles - so your provider can document your medication and dosages. This will save you the time of writing out all of those complicated drug names.

Again, thank you so much for coming to see us - I'm sure you will be pleased with the care you will receive right here in Shingletown - so close to home!

If you, should have any questions, don't hesitate to call!

Very truly yours,

Tami Fraser

Tami Fraser
Cheif Executive Officer

SHINGLETOWN MEDICAL CENTER

Patient Information Sheet

PLEASE FILL IN ALL REQUESTED INFORMATION

PATIENT INFORMATION – PRINT CLEARLY			
LAST NAME	FIRST NAME		M.I.
PHYSICAL ADDRESS	CITY	STATE	ZIP
MAILING ADDRESS	CITY	STATE	ZIP
SOCIAL SECURITY #	DATE OF BIRTH	PHONE	
DRIVERS LICENSE # / STATE **PLEASE PRESENT ID TO RECEPTIONIST**		MARITAL STATUS ☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ WIDOWED	
GENDER AT BIRTH ☐ MALE ☐ FEMALE	GENDER IDENTITIY ☐ MALE ☐ TGM-F ☐ OTHER ☐ FEMALE ☐ TGF-M	SEXTUAL ORIENTATION ☐ STRAIGHT ☐ BISEXUAL ☐ LESBIAN / GAY ☐ SOMETHING ELSE	
EMAIL	WORK PHONE	☐ FULL TIME ☐ PART TIME ☐ SEASONAL	
ETHNIC GROUP **(OPTIONAL)** ☐ HISPANIC / LATINO ☐ BLACK ☐ NATIVE AMERICAN / ALASKAN NATIVE ☐ ASIAN ☐ WHITE ☐ PACIFIC ISLANDER / NATIVE HAWAIIAN		VETERAN? ☐ YES ☐ NO	INTERPRETATIVE SERVICES REQUIRED ☐ YES ☐ NO
PRIMARY LANGUAGE	☐ DISABLED ☐ EMPLOYED ☐ RETIRED ☐ STUDENT ☐ UNEMPLOYED ☐ HOMELESS		
EMERGENCY CONTACT NAME	DATE OF BIRTH	PHONE	

RESPONSIBLE PARTY INFORMATION - IF DIFFERENT FROM PATIENT			
LAST NAME	FIRST NAME		M.I.
PHYSICAL ADDRESS	CITY	STATE	ZIP
MAILING ADDRESS	CITY	STATE	ZIP
HOME PHONE	WORK PHONE	SOCIAL SECURITY #	
DATE OF BIRTH	DRIVERS LICENSE #	RELATIONSHIP TO PATIENT	
EMPLOYER & EMPLOYER ADDRESS		☐ FULL TIME ☐ PART TIME ☐ SEASONAL	

INSURANCE INFORMATION - PLEASE PRESENT CARDS TO RECEPTIONIST - WE WILL NEED A COPY FOR BILLING		
PRIMARY INSURANCE	ID#	GROUP #
ADDRESS	NAME OF INSURED	
EMPLOYER	DATE OF BIRTH	RELATIONSHIP TO PATIENT
SECONDARY INSURANCE	ID#	GROUP #
ADDRESS	NAME OF INSURED	
EMPLOYER	DATE OF BIRTH	RELATIONSHIP TO PATIENT

Consent To Treat:
In addition to the meclical consent I hereby give consent for behavioral health treatment, if recommended. This agreement signifies that I have been informed via the "Patient Handbook" of my rights. I acknowledge that I may refuse or discontinue any behavioral health process at any time, that I understand the limits to confidentiality and the providers herein are required reporters of any abuse perpetrated on another human or property, that if in the opinion of the treating behavioral health provider there is eminent danger to another. It is their duty to warn the intended victim and authorities, that this clinic is an integrated model and that medical and behavioral health providers consult with one another in a private and confidential manner about my needs and treatment.

Consent, Release, and Assignment:
Treatment: I consent to be examined and receive treatment at Shingletown Medical Center. I, _____, understand that I may be examined by a nurse practitioner and that there is a supervising physician available for consultation at all times. I also understand that I may request to be seen by a physician.

Insurance: I authorize my insurance benefits be paid directly to Shingletown Medical Center, Inc., and authorize release any information required to process this claim. I understand that I may be responsible for non-covered charges.

Signature _____ **Date** _____

Patient # _____

Authorization for Disclosure of Information

In an effort to protect your healthcare information please list any/all names and relations of those who we have your permission to discuss appointment dates, times, billing, and medical information. (Example: spouse, significant other, parents, physicians, caretaker, etc.)

Please check the box next to your emergency contact.

Name	**Relation**	**Phone**	☐
Name	**Relation**	**Phone**	☐
Name	**Relation**	**Phone**	☐
Name	**Relation**	**Phone**	☐

Do you authorize our office to leave messages on your home and/or cell phone? ☐ **Yes** ☐ **No**

I have reviewed this consent form and am giving my permission to Shingletown Medical Center to use and disclose my health information in accordance.

Name of Patient _____

Signature of Patient or Guardian _____

Relation to Patient _____

Date Signed _____

Patient Printed Name _____ **Patient #** _____

Consent to Treat:

I hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed necessary by the providers and staff of the Shingletown Medical Center to me or to the above named minor of whom I am the parent or legal guardian. I understand I may be examined and treated by a Nurse Practitioner.

Insurance and Billing:

I hereby certify that, to the best of my knowledge, all statements contained here in are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents. I authorize my insurance benefits be paid directly to Shingletown Medical Center and I authorize SMC to release information requested by my insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

Notice of Privacy Practices:

I understand that as part of my healthcare, Shingletown Medical Center originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand the Shingletown Medical Center's Notice of Privacy Practices. The Notice of Privacy practices provides a complete description of the uses and disclosures of my health information.

I understand that:

- I have the right to review Shingletown Medical Center's Notice of Privacy Practices prior to signing this acknowledgement.
- Shingletown Medical Center reserves the right to change their Notice of Privacy practices and prior to any change I will be mailed a copy of the revisions to the address I have provided the health center.

Shingletown Medical Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SMC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Patient or Guardian Signature _____ **Date** _____

SHINGLETOWN MEDICAL CENTER

Sliding Fee Discount Program

ELIGIBILITY REQUIREMENTS AND IMPORTANT PATIENT INFORMATION ABOUT YOUR MEDICAL / BEHAVIORAL SERVICES

Shingletown Medical Center (SMC) offers a "Sliding Fee Discount" program. Many individuals qualify for the Sliding Fee Program and can receive low cost health and behavioral services. To qualify, an individual must meet Federal income criteria.

PLEASE INITIAL EACH LINE THAT YOU HAVE READ AND AGREE:

Requirements of the "Sliding Fee Discount" program:

1. _____You must complete the Fee Discount Application form every year to determine your eligibility and discount. This information includes:
   a. Your **total** household income from all income sources **before taxes**
   b. Number of family members living in your household
2. _____You must provide proof of your **total household income** prior to discount being applied. This can be in the form of check stubs, bank statements, tax returns, or any other document that proves your household income.
3. _____Your discount may vary if your income changes.
4. _____Your fee is due at each visit.
5. _____Services offered under the Shingletown Medical Center "Sliding Fee Discount" are limited to those deemed medically necessary by appropriate Medical Center staff.

Important Note: Some services may include additional charges and may not be subject to a Sliding Fee discount.

Medical Service Exclusions:

1. _____ **Lab Services:** If your health care provider orders lab work, (blood or urine test, etc.), you will get a discount if they are basic lab tests, drawn at om facility. Shingletown Medical Center staff can tell you what the tests will cost. The lab charges are payable at the time of the visit. It will be yom responsibility to pay 100% of the charge if any other lab is used or for any lab work that must be sent away for testing.
2. _____ **X-Ray Services & Special Studies:** Your health care provider may order special diagnostic studies (such as ax-rays, sonograms or CT) that are not performed at Shingletown Medical Center. You will be responsible for 100% of these charges and must make arrangements to pay the facilities that provide them.

Please let us know if you have any questions about our programs or services. We are here to assist you.

Signature _____ **Patient Number** _____ **Date** _____

Date _____

SHINGLETOWN MEDICAL CENTER

Sliding Fee Discount Program

FOR ALL PATIENTS TO FILL OUT FOR OUR GRANT REPORTING

Responsible Party _____ **Patient Name** _____

Address _____ **City / State** _____ **Zip** _____

Patient # _____ **Home Phone** _____ **Cell Phone** _____

Employment Wages (A) $ _____ **Are you paid** ☐ **Monthly** ☐ **Every 2 Weeks** ☐ **Weekly** ☐ **Twice a Month**

Other Sources of Income	**Monthly Amount**
Child Support / Alimony	$ _____
Unemployment	$ _____
Disability / Workers Comp	$ _____
Interest / Dividends	$ _____
Social Security / SSI (Including Veterans' and Suvivor Benefits)	$ _____
Pensions	$ _____
Rental Income	$ _____
Public Assistance	$ _____
Education Assistance	$ _____
Self Employment (Attach Form)	$ _____
Other (List Source)	$ _____
Total (B)	**$** _____

Household Members

*Persons related by birth, marriage or adoption

1. Self _____	1
2. Spouse _____	
***Dependents:**	
3. _____	
4. _____	
5. _____	
6. _____	
7. _____	
8. _____	
Total Members	_____

***Before sliding fee application can be processes, proof of income must be submitted. (i.e. Paystubs, Bank Statements, Taxes, etc.)**

If no income is reported, a note explaining your living situation and how your monthly expenses are being met must be written on the back of this form.

This application is only good for one (1) year. The discount can only be applied to balanced 30 days prior to appication.

I understand that giving false information will result in the denial of discount benefits, that I will be responsible for the full fee and no longer be eligible for the Sliding Fee Discount program.

Applying for a discount does not guarantee that you will receive a discount. If you fail to notify us of any changes in income or family size the clinic may immediately reverse anty discounts.

By signing below you are authorizing the release of information to SMC to verify all stated information on the Sliding Fee Discount program at our discretion.

Applicant's Signature _____ **Date** _____

This application does not bind other agencies to honor the awarded discount, and they may request additional information.

SHINGLETOWN MEDICAL CENTER

Authorization to Release Information

Name of Patient _____ **AKA** _____

Phone _____ **Date of Birth** _____ **Patient Number** _____

Address _____ **City / State** _____ **Zip** _____

SMC Provider _____

Patient Pharmacy _____ **City** _____

I authorize the use or disclose the above named individuals health information as described below:

Please provide the following information within 15 days:

- Progress notes from the last 2 years
- All consultation reports
- All imaging reports
- All mammograms, colonoscopies, paps and EKG's
- Laboratory results from the last 2 years
- Immunization records
- Current problem list with medications and allergies
- Other - Please Specify: _____

DISCLOSURE OF INFORMATION TO BE MADE FROM:

Name of Facility Releasing Records: _____

Mailing Address: _____

DISCLOSURE OF INFORMATION TO BE MADE TO:

Name of Facility Records Released To: _____

Mailing Address: _____

For the Purpose Of: _____

Patient Name _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have the right to cancel this authorization at any time. I understand that if I cancel this authorization, I must do so in writing and present my written cancellation to the Business Office Manager. I understand that it will not apply to information that has already been released in response to this authorization. I understand that the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise cancelled, this authorization will expire on the following date _____. If I fail to specify an expiration date, event, or condition this authorization will expire in six months from date of signing.**

I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or have copied the information to be used or disclosed as provided in CFR 164.524. I understand that the information disclosed might be re-disclosed and that the re-disclosure may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information I can contact the Shingletown Medical Center Office Manager at (530) 474-3390.

I understant that there may be a fee charged for processing this request.

_____ _____

Signature of Patient or Legal Representative ***Date***

_____ _____

Relationship to Patient if Legal Representative ***Signature of Witness***

Shingletown Medical Center provides primary medical and behavioral health care. We do not provide chronic pain management. If you need opioid medications or other controlled substances for chronic pain we will be happy to refer you to a pain management specialist. Our providers will not prescribe these medications for you.

Signature	***Date***

SHINGLETOWN MEDICAL CENTER

Dear Patient,

Effective May 10, 2021

Due to a new contract with Quest labs and current insurance guidelines, Shingletown Medical Center (SMC) will no longer be able to courtesy bill your insurance company for your lab tests. Quest will be billing your insurance for you.

Please contact Quest Diagnostics with any lab billing questions or issues. Quest does have a sliding fee scale, for those that qualify, and we have attached flyers from Quest with additional information.

If you have any further questions, you can always contact our billing office at (530) 474-1399.

Thank you,

Shingletown Medical Center

_____ _____

Patient Name (Printed) ***Patient Signature***

_____ _____

Patient Number ***Date***

We help patients pay for the lab testing they need to stay healthy

Quest Diagnostics Patient Assistance Program tailors solutions for patients based on their individual circumstances and may adjust some or all laboratory charges if they cannot afford to pay. Patients may qualify for one or both:

Financial Assistance Program

Tiered discounts that take into account the patient's income and family unit size based on guidelines provided by the U.S. Department of Health and Human Services. Discounts can be as much as 100% of the patient bill.

Installment Payment Plans

For patients who have the ability to pay for lab services, but need additional time, monthly payment plans are available as well.

To learn more visit:

QuestDiagnostics.com/PatientAssistanceProgram

QuestDiagnostics.com

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Shingletown Medical Center is committed to the safety, healing and well being of others.

Because of this, aggressive behavior will not be tolerated toward or from anyone, including patients, visitors, volunteers, students, and/or healthcare professionals.

Examples of aggressive behavior include:

- **Physical assault**
- **Physical, verbal, or written threats**
- **Intimidating or aggressive posturing**
- **Verbal harassment, abusive language directed at others**
- **Failure to respond to staff instruction**

All incidents will be addressed and may result in removal from facilites, dismissal from Shingletown Medical Center services, and prosecution under the law.

SHINGLETOWN MEDICAL CENTER

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR RIGHTS

When it comes to your health information, you have certain rights. You have the right to:

Get a copy of your paper or electronic medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Correct your paper or electronic medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communication

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit the information we share

- You can ask us not to use or share certain health information for treatment, payment or operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared your information

- You can ask for a list (accounting) of the times we’ve shared your health information for 6 years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make), We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to recieve the notice electronically. We will provide you with a paper copy promptly.

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 will 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 us at (530) 474-3390.
- You can file a complaint with the Chief Executive Officer, with any of the Senior Management team of SMC, or with the secretary of Health and Human Services.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you have some choices in the way that we use and share information:

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- 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 imminet threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we use or share your health information? We may use and share your information as we:

Treat you

- We can use your health information and share it with other professionals who are treating you. ***Example:*** *A doctor, nurse practitioner or nurse treating you for an injury or illness asks another doctor about your overall health condition. We may also share your health information to other healthcare providers who may be involved in your care such as specialist, therapists, and hospitals to assist them in your care or treatment.*

Run our organization

- We can use and share your health information to run our practice, improve your care and contact you when necessary. ***Example:*** *We use health information in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.*

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities. ***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

Help with public health and safety issues

- We can share health information about you for certain situations such as: Preventing disease, Helping with product recalls, Reporting adverse reactions to medications, Reporting suspected abuse, Neglect or domestic violence, Preventing or reducing a serious threat to anyone's health or safety.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Dept of Health & Human Services if it wants to see that we're complying with federal privacy law.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health infonnation about you: For workers' compensation claims, For law enforcement purposes or with a law enforcement official, With health oversight agencies for activities authorized by law, For special government functions such as military, national security, and presidential protective services.

Respond to lawsuit and legal actions

- We can share health information about you in response to a court of administrative order, or in response to a subpoena.

OUR 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 infonnation 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.

Changes to the Terms of this Notice:
We can change the terms of this notice, and the changes will apply to all informalion we have about you. The new notice will be available upon request, in our office, and on our website.

09-04-2014

PRIVACY CONTACT:

Tammy Rizzi
Business Office Manager
(530) 474-3390 ext. 322

PRIVACY OFFICER:

Tami Fraser
CEO
(530) 474-3390 ext. 307

SHINGLETOWN MEDICAL CENTER

Notice of Privacy Practices Patient Acknowledgement Form

I, _____ , (patient's name) understand that as part of my healthcare, Shingletown Medical Center originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that Shingletown Medical Center's **Notice of Privacy Practices** provides a complete description of the uses and disclosures of my health information.

I understand that:

- I have the right to review Shingletown Medical Center's Notice of Privacy Practices prior to signing this acknowledgement.
- Shingletown Medical Center reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness _____

Printed Name of Individual or Legal Representative _____

Printed PATIENT Name, if Different from Above _____

Witness _____ **Date** _____

FOR OFFICE USE ONLY

We attempted to obtain written acknoledgement of receipt of our Notice of Privacy Practices, but if could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement

_____ _____

Staff Signature ***Date***

SHINGLETOWN MEDICAL CENTER

Advanced Health Care Directives - Information Sheet

An Advance Health Care Directive lets you name someone to make treatment decisions for you. That person can make most medical decisions, not just those about life, sustaining treatment when you can't speak for yourself. Besides naming an agent, you can also use the form to say when you would and wouldn't want particular kinds of treatment.

Who makes the decisions about my treatment? Generally, you do, although there are some exceptions spelled out in laws and regulations. You have the right to agree to treatments you want to receive and to refuse treatments you don't want to receive.

How do I get information to make my decisions? Your doctor must inform you about your medical condition and about what different treatments can do for you. Your doctor must also tell you about serious problems that medical treatment is likely to cause you.

What if I'm too sick to decide? You can use an Advance Health Care Directive to name someone to make treatment decisions for you when you can't. You can also use the Advance Health Care Directive to write down your wishes about medical treatment ahead of time. That way the person you have named will know what you want.

Who can I name to make the decisions for me when I'm too sick to decide? An adult who you trust to make decisions for you as your agent.

What if I don't name someone to make treatment decisions for me when I can't? If you can't make the decisions yourself, someone will have to make the decisions for you. If you haven't named someone to make the decisions when you can't, then it may fall to your family or the doctor to make the decisions. By writing down your wishes about medical treatment ahead of time, you can let them know what you want, even if you haven't named someone to decide for you.

Do I have to use a special form? You don't have to use the form, but using a form that meets the legal requirements for an Advance Health Care Directive will make it easier for doctors to follow your wishes if someone, such as a relative, disagrees with what you wrote down that you wanted. If you don't use the form, you can write down your wishes about your medical treatment on a piece of paper. In fact, you can tell the doctor what you want and ask the doctor to write it down. Again, using the form makes it more likely that your wishes will be followed.

What if I change my mind? You can change or revoke what you wrote or told the doctor just by telling the doctor that you have changed your mind.

Do I HAVE to fill out an Advance Health Care Directive? No, it is completely voluntary.

If I do fill one out, what do I do with it? It is your responsibility to give your healthcare providers a copy. Be sure to keep one for yourself.

How can I get more information about Advance Health Care Directives? Ask your care coordinator or your doctor to get more information for you.

SHINGLETOWN MEDICAL CENTER

Medical Refill Instructions

FOR ALL REGULAR REFILLS ON YOUR MEDICATIONS,
PLEASE CALL YOUR PHARMACY.

SECURITY PRESCRIPTIONS ARE DONE AT YOUR PROVIDER APPOINTMENT.
(Please make regular appointments with your provider to get these filled)

***For refill problems, mail order refills, or sample medications, call the medication line at (530) 474-3390, press 3 and follow the instructions below:**

1. Call at least 3 business days prior to running out of medication.
2. Leave your full name and spell your last name. Speak clearly.
3. Say the name of the medication(s). **DO NOT** leave the refill number, this is for pharmacy use only.
4. State the strength of the medication you are currently taking, the name of the pharmacy you would like to use, and the phone number where you may be reached.

Please allow a minumum of 3 business days for your request to be processed. It required approval by your provider.

It is only necessary to call the medication line once. The medication line is not a regular answering machine, so all messages need to be kept short and be for refill problems only.

**For all other requests or medical problems,
please call the main office at (530) 474-3390.**

The Shingletown Medical Center staff greatly appreciates your cooperation with this policy in order to provide you with a timely response to your medication problems.