MANHATTAN FREE CLINIC

FLINT HILLS COMMUNITY CLINIC INC.

PATIENT PROFILE

First: _____ Middle: _____ Last: _____

DOB: ___ / ___ / ___ Sex: M / F SSN:_____

Ethnicity:
- ☐ African American
- ☐ Asian
- ☐ Caucasian
- ☐ Middle Eastern
- ☐ Native American
- ☐ Other _____

Race:
- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ White
- ☐ Native American
- ☐ Asian
- ☐ Hawaiian / Pacific Islander
- ☐ Multi
- ☐ Pakistan
- ☐ Unknown
- ☐ Other _____

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

Language: _____

Education: _____

☐ Veteran ☐ US Citizen ☐ US Resident ☐ Head of Household

Address: _____ City: _____ State: _____ Country: _____

County: _____ If not residing in Riley County, reason for service: _____

Home and / Cell Phone: _____ Work Phone: _____ Ext: ____

Email: _____

Emergency Contact: _____ Phone: _____

Relation: _____ Do we have authorization to release information: Yes ☐ No ☐

Is Patient covered by:
- ☐ Insurance
- ☐ Medicaid
- ☐ Medicare
- ☐ VA Benefits
- ☐ Other

Paperwork(s) provided:
- ☐ Photo ID
- ☐ Proof of Address
- ☐ Proof of Income

Proof of Income: two or three consecutive paystubs, a letter from employer and/or person and/or organization such as a charity or shelter who's aiding in financial needs and/or housing, 1040 form from tax returns.

Patient Signature: _____ Date: _____

HOUSEHOLD INCOME INFORMATION:

Total number of household: _____ Number of children: _____

Below list the people that provide income within the household **including the Patient**. FHCC requires proof of income from each individual listed within the household.

1. First: _____ Middle: _____ Last: _____

   DOB: ___ / ___ / ___ Sex: M / F Relation: _____

Race:
- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ Native American
- ☐ Asian
- ☐ Hawaiian / Pacific Islander
- ☐ Multi
- ☐ Pakistan
- ☐ Unknown
- ☐ Other _____

Employment:
- ☐ Disabled
- ☐ Employed- Part-time
- ☐ Employed- Full-time
- ☐ Minor
- ☐ Retired
- ☐ Unemployed

Monthly Income

Salary/Wages: _____
Child Support: _____
Unemployment: _____
Disability: _____
Social Security: _____
Other: _____
Total Income: _____

2. First: _____ Middle: _____ Last: _____

   DOB: ___ / ___ / ___ Sex: M / F Relation: _____

Race:
- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ Native American
- ☐ Asian
- ☐ Hawaiian / Pacific Islander
- ☐ Multi
- ☐ Pakistan
- ☐ Unknown
- ☐ Other _____

Employment:
- ☐ Disabled
- ☐ Employed- Part-time
- ☐ Employed- Full-time
- ☐ Minor
- ☐ Retired
- ☐ Unemployed

Monthly Income

Salary/Wages: _____
Child Support: _____
Unemployment: _____
Disability: _____
Social Security: _____
Other: _____
Total Income: _____

Patient Signature: _____ Date: _____

3. First: _____ Middle: _____ Last: _____

DOB: ___ / ___ / ___ Sex: M / F Relation: _____

Race:
- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ Native American
- ☐ Asian
- ☐ Hawaiian / Pacific Islander
- ☐ Multi
- ☐ Pakistan
- ☐ Unknown
- ☐ Other _____

Employment:
- ☐ Disabled
- ☐ Employed- Part-time
- ☐ Employed- Full-time
- ☐ Minor
- ☐ Retired
- ☐ Unemployed

Monthly Income

Salary/Wages: _____
Child Support: _____
Unemployment: _____
Disability: _____
Social Security: _____
Other: _____
Total Income: _____

4. First: _____ Middle: _____ Last: _____

DOB: ___ / ___ / ___ Sex: M / F Relation: _____

Race:
- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ Native American
- ☐ Asian
- ☐ Hawaiian / Pacific Islander
- ☐ Multi
- ☐ Pakistan
- ☐ Unknown
- ☐ Other _____

Employment:
- ☐ Disabled
- ☐ Employed- Part-time
- ☐ Employed- Full-time
- ☐ Minor
- ☐ Retired
- ☐ Unemployed

Monthly Income

Salary/Wages: _____
Child Support: _____
Unemployment: _____
Disability: _____
Social Security: _____
Other: _____
Total Income: _____

5. First: _____ Middle: _____ Last: _____

DOB: ___ / ___ / ___ Sex: M / F Relation: _____

Race:
- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ Native American
- ☐ Asian
- ☐ Hawaiian / Pacific Islander
- ☐ Multi
- ☐ Pakistan
- ☐ Unknown
- ☐ Other _____

Employment:
- ☐ Disabled
- ☐ Employed- Part-time
- ☐ Employed- Full-time
- ☐ Minor
- ☐ Retired
- ☐ Unemployed

Monthly Income

Salary/Wages: _____
Child Support: _____
Unemployment: _____
Disability: _____
Social Security: _____
Other: _____
Total Income: _____

Patient Signature: _____ Date: _____

ATTENTION FHCC PATIENTS WITH NO INCOME

The clinic is authorized to provide care to medically indigent persons, those who have no access to health care via insurance or government programs and whose income is less than 200% of the current government standards.

The provision of income information such as pay vouchers, unemployment benefits, or other income is essential to insure we meet those requirements.

If you have indicated that you have no income, please provide a statement below which explains how you are meeting your needs. **How do you pay for housing, food, and other needs? Is an individual or organization helping you? Give a rough estimate of monthly aided funds.**

Patient Signature: _____ Date: _____

PATIENT HISTORY

Please check all that apply.

- ☐ Allergies
- ☐ Anemia Anticoagulation
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding
- ☐ Bowel Disease
- ☐ COPD
- ☐ Depression
- ☐ Dental Disease
- ☐ Diabetes
  - ☐ Type I
  - ☐ Type II
- ☐ Diarrhea
- ☐ Eye Disease
- ☐ Epilepsy
- ☐ GERD
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Back Pain
- ☐ Major Blood Vessel Disease
- ☐ Mental Illness
- ☐ Migraines
- ☐ Multiple Sclerosis or Nerve Disease
- ☐ Musculoskeletal Disorder
- ☐ Neuropathy
- ☐ Obesity
- ☐ Peripheral Arterial Disease
- ☐ Prostate
- ☐ Thyroid
- ☐ Transfusions
- ☐ Skin Disorder
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Cancer

INFECTIOUS DISEASES

- ☐ AIDS or HIV
- ☐ Cholera
- ☐ Chicken Pox
- ☐ Dengue
- ☐ Ebola
- ☐ Encephalitis
- ☐ Guinea Worm
- ☐ Hepatitis
- ☐ Malaria
- ☐ Measles
- ☐ Mumps
- ☐ Parasite Infection
- ☐ Poliomyelitis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Tetanus
- ☐ Trachoma
- ☐ Tuberculosis
- ☐ Whooping Cough

Cancer(s) (Type): _____

Relative Date(s): _____

Heart Disease: _____

Relative Date: _____

Venereal Disease (Type): _____

Relative Date: _____

Surgery/Hospitalizations(s): _____

_____

Relative Date(s): _____

Other : _____

_____

Allergies

_____

_____

_____

_____

_____

_____

_____

_____

Pertinent Family History: _____

Preferred Pharmacy: _____

Patient Signature: _____ Date: _____

MEDICAL INFORMATION RELEASE FORM

HIPAA RELEASE FORM

Patient Name: _____ Date of Birth: _____

I authorize the release of information including the diagnosis, records, examination, appointment information rendered to me and claims information. This information may be released to:

Name	Phone Number	Relation
1.		
2.		
3.		
4.		
5.		

Message

FHCC will use the contact information provided on the Annual Eligibility update form and or the Patient Packet to contact the patient.

If unable to reach the patient:

- ☐ We may leave a detailed message
- ☐ Leave a brief message asking to return the phone call
- ☐ Other: _____

Preferred time to contact: _____

Patient Signature: _____ Date: _____

MANHATTAN FREE CLINIC

FLINT HILLS COMMUNITY CLINIC INC.

SMOKING SURVEY

Patient Name: _____ Date:_____

Please answer the following questions regarding your smoking history.

- ☐ Never Smoked
- ☐ Quit Smoking
- ☐ Current Smoker

How Long? _____

What age did you start? _____

Do you want to quit? Y / N

Feel free to add comments regarding any failed attempts/methods, and/or how many times you tried to quit before quitting successfully.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature: _____ Date: _____

PATIENT NOTICE OF PRIVACY PRACTICES

Flint Hills Community Clinic

As required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 996-(HIPAA) Health Information Technology for Economic and Clinical Health Act (HITECH Act), and associated regulations and amendments. This notice describes how health information about you may be used and disclosed, and how you can get access to this information.

PLEASE REVIEW THIS NOTICE CAREFULLY
If you have any questions about this notice or if you need more information, please contact
Flint Hills Community Clinic
(785) 323-4351 or email fhcc05@gmail.com
401 Houston Street, Suite C
Manhattan, KS 66502

ABOUT THIS NOTICE

We understand that health information about you is personal and we are committed to protecting your information. We create a record of the care and services you receive at all divisions of **Flint Hills Community Health Clinic**. We need this record to provide care (treatment), for payment of care provided, for health care operations, and to comply with certain legal requirements. This notice will tell you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to follow the terms of this notice that is currently in effect.

WHAT IS PROTECTED HELTH INFORMATION ("PHI")

PHI is information that individually identifies you. We crate a record or get from you or from another health care provider, health plan, your employer, or health care clearyinghouse that relates to:

- Your past, present, or future physical or mental health or conditions,
- The provision of health care to you, or
- The past, present, or future payment for your health care.

HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use and disclose your PHII in the following circumstances:

Treatment. We may use or disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your PHI may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health provider has the necessary information to diagnose or treat you or provide you with service.

Payment. We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for the treatment.

Patient Signature: _____ Date: _____

Health Care Operations. We may use and disclose PHI for our health care operations. For example, we may use your PHI to internally review the quality of the treatment and serviced you receive and to evaluate to performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

Minors. We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Research. We may use and disclose your PHI for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of any PHI. We may disclose PHI to be used in collaborative research initiatives amongst **Flint Hills Community Clinic** providers. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if wee enter a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

As Required by Law. We will disclose PHI about you when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Heath or Safety. We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

Business Associates. We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of the PHI.

Organ and Tissue Donation. If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may disclose PHI as required by military command authorities. We also may disclose PHI to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2)prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Abuse, Neglect, or Domestic Violence. We may disclose PHI to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

Health Overnight Activities. We may disclose PHI to a health overnight agency for activities authorized by law. These overnight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves in the event of a lawsuit.

Law Enforcements. We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes.

Military Activity and National Security. If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your PHI to authorized officials so they may carry out their legal duties under the law.

Coroners, Medical Examiners, and Funeral Directors. We may disclose PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

Individuals Involved In Your Care. Unless you object in writing, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement.

Payment for Your Care. Unless you object in writing, you can exercise your rights under HIPAA that your healthcare providers not disclose information about services received when you pay in full out of pocket for the service and refuse to file a claim with your health plan.

Disaster Relief. We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Fundraising Activities. We may use or disclose your PHI, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications.

Your Written Authorization if Required for Other Uses and Disclosures

The following uses and disclosures of your PHI will be made only with your written authorization:

- Most uses and disclosures of psychotherapy notes;
- Uses and disclosures of PHI for marketing purposes; and
- Disclosures that constitute a sale of your PHI

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do not give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your PHI. You have the following right, subject to certain limitations, regarding your PHI:

Inspect and Copy. You have the right to inspect, receive, and copy your PHI that may be used to make decisions about your care or payment for your care. We have up to **30 days** to make you PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated wit your request. You can only direct us in writing to submit your PHI to a third party not covered in this notice. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Summary or Explanation. We can also provide you with a summary of your PHI, rather than the entire record, or we can provide you with an explanation of the PHI which has been provided to you, so long as you agree to this alternative form and pay the associated fees.

Electronic Copy of Electronic Medical Records. If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. If the PHI is not readily producible in the form or format you request your record will be provided in a readable hard copy form.

Receive Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured PHI.

Request Amendments. If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request the amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Accounting of Disclosures. You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your PHI. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the

list. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or heath care operations. We are not required by federal regulation to agree to your request. If we do agree with your request, we will comply unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Your request must state the specific restriction requested, whether you want to limit our use and/or disclosure; and to whom you want the restrictions to apply.

Request Confidential Communications. You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at you work phone number. Yu must make any such request in writing and you must specify how or where we are to contact you.

Paper Copy of this Notice. You have the right to a paper copy of this notice, even if you have agreed to receive this notice electronically. You may obtain a copy of this notice by visiting out website: *www.doctorbewell.com* or contact the **Be Well Medical Center** office you are receiving serviced from.

Changes to this Notice. We reserve the right to change this Notice. We reserve the right to make the changed notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current notice is posted in our office ad on our website.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the **Flint Hills Community Clinic** Privacy Officer, at the address listed at the beginning of this notice or with the Secretary of the U.S Department of Health and Human Services. To file a complaint with the Secretary, mail it to : Secretary of the U.S Department of Health and Human Services, 200 Independence Ave., S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free: (877) 696-6775 or got to the website of the Office for Civil Rights, www.hhs.gov/ocr/jippa/, for more information. **You will not be penalized for filing a complaint.**

FLINT HILLS COMMUNITY CLINIC
ACKNOWLEDGEMENT OF RECEIPT OF
PATIENT NOTICE OF PRIVACY PRACTICES

I acknowledge that I read and/or received a copy of the **Flint Hills Community Clinic** Patient Notice of Privacy Practices effective September 23, 2013.

Please submit all requests in writing to our Medial Records Department, 401 Houston Street, Suite C, Manhattan, KS 66502. There may be a charge for transferring medical records.

If you have any questions regarding this notice or the HIPAA privacy policies, please contact the clinic at (785) 323-4351 pr through email at fhcc05@gmail.com

Patient Signature: _____ Date: _____

MANHATTAN FREE CLINIC

FLINT HILLS COMMUNITY CLINIC INC.

Patient Agreement and Treatment Policies

Eligibility

Flint Hills Community Clinic will treat individuals who meet the following eligibility requirements:

- Uninsured (no health benefits or coverage, including Medicaid, Medicare or 3rd party insurance)
- Resident of Riley County and/or the City of Manhattan
- Household income is at or below 200% of the federal poverty level.

Patients will be required to provide the clinic with proof of residency and household income. The clinic reserves the right to request documentation of a patient's eligibility at any time. If a patient no longer meets the eligibility requirements, the clinic will no longer provide services to that individual. Eligibility updates are required annually.

If these conditions are met, all services will be provided at no charge. If there are Lab charges you may be asked for a nominal fee. No one will be denied services based on their ability to pay said fee. These charges will be written off to charity care.

Services

All patients at FHCC are seen by a Physician, Physician's Assistant (PA), Nurse Practitioner (ARNP) or other licensed professional in the state of Kansas. Services are provided free of charge and include primary and acute health care. The clinic cannot treat emergencies or pregnancies. Payment for medical treatment sought outside of the clinic, including emergency room visits, will be the sole responsibility of the patient.

Medications

FHCC is not responsible for the payment of patients' prescriptions. Samples may be given to patients **if available;** however the clinic is not guaranteed to have specific medication samples on site for distribution to its patients. Patients are responsible for obtaining any ongoing medications and the costs associated with them. FHCC does not have stock medications on site for distribution to its patients. Enrollment assistance may be given to patients for various patient assistance programs through the pharmaceutical companies for ongoing prescriptions. If you need help with medications we do offer a PPAP (Pharmaceutical Patient Assistant Program)

Certain medications are available through pharmaceutical companies free to people based upon income. An application will be submitted to the program. If you qualify, you will be contacted to come

Patient Signature: _____ Date: _____

back to the office to sign the application. Medications will not be given to patients until the application is signed and submitted.

Patients are responsible for notifying their pharmacy if they are in need of a refill. Patients should call their pharmacy no less than **TEN DAYS** before a medication runs out. FHCC providers will NOT prescribe controlled substances.

Referrals

Referrals to specialty physicians are made only when deemed medically necessary by one of our providers. These referrals are made only as available and are not guaranteed. Patients may be responsible for a co-pay or a portion of the cost of these visits and will be required to show documentation of household income. It is the responsibility of the patient to contact the referred specialist regarding their cost prior to the consultation appointment. The patient is responsible to check with the referral if financial assistance is available.

Patient Attendance Policy

Patients are expected to notify the clinic if they cannot keep a scheduled appointment. If the appointment is an evening appointment, notification of a cancelled appointment is to occur by **NOON** on the day of the appointment so that we may give that appointment slot to another patient on our waiting list. If the appointment is an afternoon appointment the cancellation must occur by **4 pm** the day before.

No Show Policy

The clinic Providers and Support Staff give of their personal time to serve you. In honor of their time and clinic resources, it is important to show up when scheduled. A no show is defined not showing for a scheduled appointment without a phone call as stated in the Patient attendance Policy. Two (2) consecutive no shows with require a conversation with our clinic coordinator before rescheduling. Poor attendance history could result in a probationary period and could lead to termination of services.

Privacy Policy

All FHCC staff and volunteers operate according to HIPAA rules and regulations. Written consent is required to release any patient information to other persons or agencies, except as required by law in the cases of court orders, child abuse, life threatening situations and national security issues. Patients' demographic information may be used for the purpose of statistics in reporting to funding sources.

Reporting Policy

FHCC staff and volunteers are required by law to report any suspicion of child, adult, elder or vulnerable person abuse including neglect, emotional, physical or sexual abuse.

Patient Signature: _____ Date: _____

Please initial each of the following statements to acknowledge that you have read them and agree to them:

_____ Flint Hills Community Clinic is not an insurance carrier.

_____ Flint Hills Community Clinic operates under the KDHE's Charitable Care Health Program

_____ I will notify the clinic by noon of the day of my (evening) appointment if I cannot keep my scheduled afternoon appointment. I will contact the clinic by 4pm the day previous to my appointment date and understand that if I do not, I will be subject to FHCC's "No Show" policy.

_____ I understand that the FHCC Board of Directors Policy states that NO prescriptions or refills for medications which are classified "Schedule II. III, IV, or V' will not be provided by physicians, nurse practitioners or physicians assistants.

_____ I understand that if I am impaired by drugs or alcohol I may be declined services at the time of the visit.

_____ I understand that services provided at the clinic are free of charge. I understand that if I am referred to a specialist I may be responsible for a portion of assessed fees. I understand that if I seek medical services outside of the clinic, including the Emergency Room, that I will be responsible for any bills incurred.

_____ I understand that I am expected to treat FHCC staff and volunteers with respect. If I am uncooperative, verbally or physically abusive, or behave in an inappropriate manner, I may be dismissed as a patient from the clinic.

_____ I understand that I am expected to be truthful with FHCC staff and volunteers about other medical services that I am receiving and medications or behaviors that may affect my medical well-being.

_____ I understand that FHCC treats individuals who meet the eligibility parameters. I understand that I am responsible for being truthful about my residency, income and insurance status and that if I provide false information about my eligibility that I will be dismissed as a patient from the clinic.

_____ I understand that I am responsible for monitoring my prescriptions and that I need to contact the pharmacy no less than TEN DAYS before my prescription runs out. I understand that if I contact the pharmacy within less than ten days of my prescription running out that I am not guaranteed an appointment to obtain a refill prescription before my medication runs out.

_____ I understand the terms and conditions of the PPAP program and the importance of timely responses to the application process. No medications will be delivered through the program until the application is completed by FHCC and the patient.

Patient Signature: _____ Date: _____

I have received a copy of the clinic's Patient Agreement and Treatment policies and I understand and agree to all of the above. I understand that if I violate any of the above-stated agreements, I may be terminated as a patient of the Flint Hills Community Clinic.

_____ _____

Patient or Guardian's Signature Date

By signing below, I acknowledge that I have no health coverage, including Kansas Medicaid, Health Wave, Medicare or any private insurance. I will notify Flint Hills Community Clinic immediately if I obtain any health benefits and understand that once I am covered under a health coverage plan that I am no longer eligible to receive services at Flint Hills Community Clinic.

_____ _____

Patient or Guardian's Signature Date

By signing below, I give Flint Hills Community Clinic permission to verify with Social and Rehabilitation Services that I do not have any health coverage provided through the state of Kansas through Medicaid, Health Wave, or any other government-issued health benefits and to verify with my employer or my spouse's employer that I do not have health insurance or benefits through the employer.

_____ _____

Patient or Guardian's Signature Date

Revised 2/25/2021 RDH

Patient Signature: _____ Date: _____