KEEP THIS PAGE

Access FAMILY HEALTH SERVICES Access SCHOOL HEALTH SERVICES

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, & HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE & DISCLOSE MEDICAL INFORMATION ABOUT YOU: The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual. For Payment. We may use and disclose medical information about you so that the treatment and services you receive at ACCESS may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you. For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at ACCESS or the hospital. For example, we may disclose medical information about you to people outside ACCESS who may be involved in your medical care, such as family members, clergy or other persons that are part of your care. For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses & disclosures are necessary to run ACCESS and ensure that all our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other ACCESS personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. **WHO WILL FOLLOW THIS NOTICE:** This notice describes ACCESS's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff, and other ACCESS personnel. **POLICY REGARDING PROTECTION OF PERSONAL INFORMATION:** We create a record of the care and services you receive at ACCESS. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by ACCESS, whether made by ACCESS personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS: You have the following rights regarding medical information we maintain about you: ***(1)*** *Right to a paper copy of this notice:* At any time, you may ask us to give you a copy of this notice at any time; ***(2)*** *Right to inspect and copy:* You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances; ***(3)*** *Right to amend:* If you feel your medical data is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for ACCESS. To request an amendment, your request must be made in writing and submitted to the Privacy Officer listed below, and you must provide a reason that supports your request. We reserve the right to deny your request for an amendment; ***(4)*** *Right to request restrictions:* You have the right to request a restriction or limitation on the medical 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 medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. 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 must make your request in writing to the Privacy Officer listed below; ***(5)*** *Right to request removal from fundraising communications:* You have the right to opt out of receiving fundraising communications from ACCESS; ***(6)*** *Right to restrict disclosures to health plan:* You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full; ***(7)*** *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. You must make your request in writing and you must specify how or where you wish to be contacted; ***(8)*** *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. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer listed below. **CHANGES TO THIS NOTICE:** We reserve the right to change this notice. We will post a copy of the current notice in ACCESS's waiting room and on our website at *accessfhs.com*. **COMPLAINTS:** If you believe your privacy rights have been violated, you may file a complaint with ACCESS or with the Secretary of the Department of Health & Human Services. To file a complaint with ACCESS, contact our Privacy Officer listed below. All complaints must be submitted in writing. You will not be penalized for filing a complaint. **OTHER USES OF MEDICAL INFORMATION:** Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer listed below.

Kyle Davis, Privacy Officer • **662-651-4637 x8105** • PO Box 305, Smithville, MS 38870

Consent for Treatment & Release of Health Information

NAME OF PATIENT: _____ DATE: _____/_____/_____

1. **CONSENT FOR TREATMENT:** I request and voluntarily consent to the usual medical services as a patient at Access Family Health Services, Inc. (here on referred to as "AFHSI" or "the clinic"), as well as the diagnostic laboratory (testing of the blood and other bodily fluids) and x-ray procedures (including intravenous injection of contrast material) and medical treatment, including administration of anesthesia and other treatment as deemed necessary by my physician, his assistants or other designated physicians. The clinic is authorized to retain, preserve, and use for scientific or teaching purposes, or dispose of, at its convenience, any specimens or tissue removed from my body during treatment.

2. **MEDICAL CARE:** During treatment at the clinic, I (the patient), will be under the professional care of a physician. I understand that no guarantees have been made as a result of examination or treatment while in the clinic.

3. **COMPLIANCE WITH RULES & REGULATIONS:** In consideration of treatment, I agree to abide by the rules of the clinic, including no smoking.

4. **PERSONAL VALUABLES:** I agree that the clinic will not be liable for the *loss of* or *damage to* any personal property that I may bring to the clinic.

5. **RELEASE & RESPONSIBILITY:** I hereby agree, acknowledge, and understand that the clinic is not responsible for injuries sustained by use of my own personal equipment – electrical, mechanical, or otherwise. I further understand and agree that if I should leave the clinic without the consent of my physician (against medical advice), I hereby relieve my physician and the clinic of all responsibility for such action.

6. **CONSENT TO DESTROY X-RAY & RADIOGRAPHIC DATA:** I hereby authorize the clinic to retire or destroy my x-ray images (film and/or digital), and any other radiographic data, four (4) years after generation, if a proper report is in the medical record.

7. **ASSIGNMENT OF BENEFITS:** As the patient or patient's representative, I make the following assignment of benefits:

   MEDICARE and/or MEDICAID • I hereby request that payment of authorized Medicare and/or Medicaid benefits to or on my behalf for services rendered in or by the clinic, shall be made to the clinic, and I specifically assign such benefits to the clinic. I hereby certify that all information I provide, in connection with applying for benefits under Title XVIII of the Social Security Act, is true, correct, and complete in all respects. **I understand that payment for services deemed not medically necessary by Medicare/Medicaid are not authorized under the Medicare/Medicaid program, and I may be responsible for the incurred charge(s), unless other third-party coverage is available.**

   INSURANCE • I hereby assign to the clinic all rights, benefits, and interest under any insurance policy, health plan, workers' compensation, or other third-party payer liable to me, in consideration for services rendered by the clinic. I hereby authorize payment directly to the clinic by any insurance policy, health plan, or third-party payer for treatment received at or by the clinic. I hereby authorize payment of workers' compensation coverage directly to the clinic for expenses incurred at the clinic. I hereby authorize payment directly to the clinic of all third-party liability insurance coverage, third-party payer, health plan, and individual liability insurance coverage for medical expenses incurred as a result of any accident, injury, or illness for which I received treatment at the clinic.
   I understand that I am responsible for ensuring that all claims are submitted to my insurance company, the submission of my insurance claims by the clinic is only as a courtesy, and there is no guarantee that all claims are properly submitted.

8. **FINANCIAL RESPONSIBILITY:** I understand that I am financially responsible to the clinic for all charges not paid by insurance. I also understand and agree that all deductibles, coinsurance, non-covered charges, and other items not paid by insurance, health plan, or other third-party payers are due and payable upon services rendered based on the best estimates available as determined by the clinic. Charges remaining on this account which are not paid by insurance, health plan, or other third-party payer, are payable upon demand. I also agree that if this account is assigned to a collection agency or attorney for collection or suit, all collection fees, attorney fees, cost, and other expenses will be paid by me. I also understand, agree, and authorize the clinic to verify employment status for the purpose of processing my clinic bill for payment.

9. **COMMUNICATION:** I authorize all clinical providers who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me using pre-recorded messages, artificial voice messages, automatic telephone dialing devices/services, or other computer-assisted technology, and/or by email, text messaging, or any other form of communication.

10. **NON-CERTIFICATION OF OUTPATIENT PROCEDURES:** I hereby agree that as the policyholder/beneficiary of insurance, health plan, or other third-party payer, I am responsible for assuring certification is obtained from the insurance company, third-party administrator, or health plan for the treatment provided. If certification is not obtained, I further agree that in the event the insurance, health plan, or other third-party payer denies all or part of the payment on services rendered, the clinic will not be liable.

11. **CONSENT FOR THE RELEASE OF HEALTH INFORMATION FOR BILLING & PAYMENT PURPOSES:** I hereby consent to the release of my health information (medical records, medical results, and all other health information) by clinic or any physician involved in my care for the purpose of: billing; claims management; medical data processing; eligibility documentation; reimbursement; and certification to any insurance company, third-party payer, health plan, or government agency which is necessary for the billing and payment of my account.

12. **FINANCIAL ASSISTANCE** (SLIDING FEE PROGRAM)**:** I understand that if I am uninsured or underinsured, financial assistance may be available. If I need assistance I can contact the clinic's sliding fee coordinator for further information about financial assistance for uninsured or underinsured patients. **I understand that sliding fee/financial assistance will be denied if I fail to truthfully and timely provide information to verify my eligibility.** I understand that my application for financial assistance/sliding fee expires one (1) year from the date of the original application, and to continue receiving financial support I must reapply if my application has expired.

13. **NOTICE OF PRIVACY PRACTICES:**
Access Family Health Services, Inc. uses SureScripts and Allscripts to electronically exchange data regarding prescriptions and related information between my providers and pharmacies. The information sent between these systems may include details of prescription drugs I am currently taking and/or have taken in the past. This information will be utilized by Access Family Health Services, Inc. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts and Allscripts to Access Family Health Services, Inc.

By signing below, I acknowledge that I have been informed of and/or received the *AFHSI Notice of Privacy Practices*. My acknowledgement does not mean I agree with or I have read the Notice of Privacy Practices.

14. **DISCLOSURE OF PERSONAL HEALTH INFORMATION:** Access Family Health Services, Inc. will not, without your authorization, discuss your personal health information with anyone except those allowed under Federal and State law or those listed below.

List the names and relationships of those you authorize us to discuss your personal health information.

Contact Name (please **print**)	Relationship (please **print**)	Contact Number
		– –
Contact Name (please **print**)	Relationship (please **print**)	Contact Number
		– –
Contact Name (please **print**)	Relationship (please **print**)	Contact Number
		– –

I, the undersigned, as the patient or patient's legal representative, have read this entire document, understand the content, and agree to the terms.

_____ ____/____/____

Signature of Patient **or** Patient's Representative Date

_____ _____

If Authorized Person signed above, what is your relationship to the patient? Clinic Witness

Patient Data Form

Last Name

First Name

Preferred Name

Middle Name

Date of Birth

Social Security #

Address

Address *(cont.)*

ZIP

City

State

County *(e.g. Monroe, Lee, etc.)*

Sex: ❑Male ❑Female

_____–_____–_____ ❑ None
Home Phone

_____–_____–_____ ❑ None
Mobile Phone

Consent to call? ❑Y ❑N ● Consent to text? ❑Y ❑N

_____–_____–_____ ❑ None
Work Phone

Patient email or **Parent/Guardian** email (if minor)
Email **required** for online services (patient portal, app, self-check-in, etc.). Portal features incl. lab results, health info, vitals, problems, secure messaging, med refills, appointments, billing/payments, and more.

Check All That Apply

Ag worker: ❑ Yes ❑ No ❑ Decline

Homeless: ❑ Yes ❑ No ❑ Decline

School-based: ❑ Yes ❑ No ❑ Decline

Veteran: ❑ Yes ❑ No ❑ Decline

Public housing: ❑ Yes ❑ No ❑ Decline

Sexual orientation:
❑ Straight ❑ Something else
❑ Gay ❑ Unknown
❑ Bisexual ❑ Decline

Gender Identity:
❑ Male ❑ Other:_____
❑ Female ❑ Decline
❑ Trans-female: male-to-female
❑ Trans-male: female-to-male
❑ Gender non-conforming

✓ Contact Preference
❑ Mobile Phone ❑ Home Phone
❑ Work Phone ❑ Patient Portal ❑ Mail

✓ Usual or Preferred Provider
(b)* = *behavioral/mental health ***(d)* = *dental/oral health***

❑ Dr. Monroe ❑ Dr. Wanee ❑ W. Carroll
❑ M. Beach[(b)] ❑ C. Searcy ❑ A. Higginbottom
❑ K. Davis ❑ Dr. Koehler ❑ B. Sumerford[(b)]
❑ A. Floyd[(b)] ❑ C. Hardin ❑ Dr. Hill[(d)]
❑ Dr. Reichenbach "Dr. Bach"[(d)]

✓ Patient's Marital Status
❑ Married ❑ Single ❑ Divorced
❑ Separated ❑ Widowed ❑ Partner

✓ Language
❑ English ❑ Non-English ❑ Decline

✓ Race
❑ White ❑ Black ❑ Other Pacific Islander
❑ Asian ❑ Decline

✓ Ethnicity
❑ Non-Hispanic | Latino ❑ South American
❑ Hispanic | Latino | Spanish ❑ Puerto Rican
❑ Central American ❑ Mexican
❑ Latin American | Latin, Latino ❑ Dominican
❑ Cuban ❑ Decline

Preferred Pharmacy

❑ Check here to use the
Smithville Clinic In-house Pharmacy.

_____
Pharmacy Name

_____
In What City?
If pharmacy has multiple locations in same city, include city and general location. (e.g. *Walgreens by hospital* or *Walgreens on Main St*)

✓ How did you hear about us?

❑ Ad ❑ Physician ❑ Specialist ❑ Hospital
❑ Word of Mouth ❑ Online/web search
❑ Another patient ❑ Social Media
❑ Other: _____

✓ How would you like to receive your *Patient Care Summary*?

❑ Online Patient Portal ❑ Paper

Emergency Contact

_____
First Name Last Name

_____–_____–_____
Phone

✓ Emergency Contact's Relationship to Patient:

❑ Spouse ❑ Parent ❑ Child
❑ Sibling ❑ Friend ❑ Grandparent
❑ Guardian ❑ Other: _____

Next of Kin ❑ Same as emergency contact.
If not checked or none listed, emergency contact will be used.

Name: _____
Phone: _____–_____–_____
Their relationship to patient: _____

Patient Employment

❑ None (student/minor) ❑ Unemployed

_____
Employer Name

_____–_____–_____
Employer Phone

_____
Patient Occupation *(current **or** most recent)*

Mother's Maiden Name

_____

Guarantor

(person who receives statements)

✓ Guarantor's relationship to patient:

❑ Self ❑ Spouse ❑ Child
❑ Grandparent ❑ Grandchild
❑ Nephew/Niece ❑ Foster Child
❑ Other ❑ Unknown

_____
Guarantor Last Name

_____
Guarantor First Name

_____/_____/_____
Guarantor Date of Birth

_____
Guarantor's Employer

_____–_____–_____
Employer phone

Mailing Address ❑ Same as patient

_____
Address 1

_____
Address 2

_____ _____ _____
Zip City State

_____–_____–_____
Social Security #

_____–_____–_____
Phone

_____
Guarantor Email
❑ *Same email as patient* ❑ *None*

Insurance Information

INSURED'S INFORMATION: So we may file your insurance correctly, please make sure the receptionist has a copy of your **current** insurance card(s) **at each visit**. It is the **patient's responsibility** to make sure we have the correct insurance on file at the time of service. Thank you!	
Primary Insurance Name	Insured's Date of Birth / /
Primary Insured's SSN – –	Policy Holder ID#
Primary Policy Holder's Name	Primary Insured's Employer
Secondary Insurance Name	Insured's Date of Birth / /
Secondary Insured's SSN – –	Policy Holder ID#
Secondary Policy Holder's Name	Secondary Insured's Employer

Would you like to apply for financial assistance?

❑ **Yes** (Find out if you qualify using the steps below.)

❑ **No** (Simply **sign & date below**, return to the receptionist, and you're done.)

Access Assistance (Sliding Fee) Program

Income amounts based on 2021 Federal Poverty Level.

COLUMN A	COLUMN B
People Living in Your Home	Annual Household Income
❑ 1	❑ $25,760
❑ 2	❑ $34,840
❑ 3	❑ $43,920
❑ 4	❑ $53,000
❑ 5	❑ $62,080
❑ 6	❑ $71,160

Using the chart above:

Step 1: In Column A, check the number of people living in your home.

Step 2: In Column B, check the amount directly across from the number you checked in Column A.

Step 3: Check the box <u>below</u> that best represents your result.

❑ My annual household income is **greater than** the amount checked in Column B, so I do not qualify.

❑ My annual household income is **less than** the amount checked in Column B, and **I want to apply.**

_____ _____/_____/_____

Signature of Patient • Parent • Guardian Date

Access FAMILY HEALTH SERVICES

Medical Clinic No-Show Policy

Your medical providers want to make sure that you and other area residents have access to high quality healthcare when you need it. To ensure maximum access to healthcare services for all of our patients, please be aware of the following No-Show Policy:

Scheduled Appointments: Although we are not obligated to do so, for your convenience we will make every effort to remind you of your upcoming appointment through our complimentary automated appointment reminder system (via phone call or text message); however, **you are ultimately responsible for remembering and keeping your appointment date and time**.

Cancelling/Rescheduling Appointments: Automated appointment reminders, via text message or phone call, are generally made two (2) days before your scheduled visit. If you cannot keep your scheduled appointment, please cancel through the reminder system (automated phone call or text reminder) or call the office to cancel/reschedule, which will allow us to offer that appointment to another patient. You can cancel/reschedule at any time without having to wait on the appointment reminder. Failure to provide at least a 24 hour notice of an appointment cancellation/reschedule counts as a missed appointment.

Missed Appointments: Because of the critical lack of access to healthcare services in our area, missed appointments are taken **very seriously**. If you miss one (1) appointment, you will be documented as having a missed appointment. If you miss a second appointment without proper notice within the same calendar year, you will be placed on "work-in" status. After you are placed in a "work-in" status, in order to receive care from our clinics, you will be given a date only (not a specific time) by the receptionist that you can come to the clinic to be worked-in, and no appointment will be scheduled. Being placed on "work-in status" in two (2) consecutive calendar years will result in discharge from Access Family Health Clinics.

Please talk to any of the staff if you have questions about our No-Show Policy.

By signing below, I understand and agree to abide by this No-Show Policy.

_____

Patient Signature Date

_____

Patient Guardian Signature *(for patients under 18)* Date