Community Health Center in Cowley County, Inc.
Westside Clinic - Winfield
Health Care for Everyone

Consent to Provide Care
With this consent, staff and providers at Community Health Center in Cowley County (CHCCC) may call, e-mail, text or utilize telehealth in reference to any items that assist the Practice in providing my medical care, such as contact information, appointment reminders, insurance related items, patient statements, and laboratory results, among other items. I have the right to request that CHCCC restrict how it uses or discloses my Personal Health Information by requesting forms from CHCCC.

Acknowledgement of Receipt of Notice of Privacy Practices (Notice of Privacy Practices are available upon request)
I acknowledge that I have been notified and understand *CHCCC's Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that the Practice may update its *Notice of Privacy Practices* at any time and I may receive an updated copy of the Practice's *Notice of Privacy Practices* upon my request at any time.

Your Rights Regarding Electronic Health Information Technology
Community Health Center in Cowley County participates in electronic health information technology or HIT. This technology allows a provider or a health plan to make a single request through a health information organization or HIO to obtain electronic records for a specific patient from other HIT participants for purposes of treatment, payment, or health care operations. HIOs are required to use appropriate safeguards to prevent unauthorized uses and disclosures. You have two options with respect to HIT. ***First,*** you may permit authorized individuals to access your electronic health information through an HIO. If you choose this option, you do not have to do anything. ***Second,*** you may restrict access to all of your information through an HIO (except as required by law). If you wish to restrict access, you must submit the required information either online at http://www.KanHIT.org or by completing and mailing a form. This form is available at http://www.KanHIT.org. You cannot restrict access to certain information only; your choice is to permit or restrict access to all of your information. If you have questions regarding HIT or HIOs, please visit http://www.KanHIT.org for additional information. If you receive health care services in a state other than Kansas, different rules may apply regarding restrictions on access to your electronic health information. Please communicate directly with your out-of-state health care provider regarding those rules.

Consent to Access External Prescription History
I authorize the providers and staff at CHCCC to view external history via eClinicalWorks/RxHub software. I understand prescription history is from other unaffiliated medical providers, insurance companies and pharmacy managers and it may be viewable by the providers and staff of CHCCC. The external history includes prescription for several years. If you wish to opt out of this, you will need to make a request in writing.

Assignment of Benefits
I request that payments of authorized benefits from Medicare, Medicaid, and/or any other insurance carrier listed, be made to CHCCC for any services furnished to me and CHCCC may release any medical information needed to determine payable benefits. I agree to pay my co-payment, required deductible and patient responsibility amounts at the time of service and to pay for services not covered by my insurance plan.

By signing this form, I am consenting to Community Health Center in Cowley County to use and disclose my Personal Health Information to provide medical care. I understand I am responsible for my bill. I have read the above information and have no further questions.

Patient Name: _____ Date of Birth: _____

Patient/Guardian Signature: _____ Date _____

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Authorization to Release/Discuss Confidential Medical Information to Specified Individual

(this form is to be filed in patient chart with information sheet)

RELEASE OF MEDICAL RECORDS RELATING TO THE FOLLOWING MUST BE INITIALED TO BY PATIENT/PARENT/GUARDIAN - **"42 CFR Part 2 prohibits unauthorized disclosure of these records"**

_____ DRUG OR ALCOHOL TREATMENT **_____ PSYCHIATRIC OR PSYCHOLOGICAL TREATMENT**
_____ HIV AND/OR AIDS STATUS **_____ OTHER PLEASE SPECIFY**

Community Health Center in Cowley County

Treasure A. Wehner, D.O. **Michelle R. Blair-Wunderlich, NP-C** **Jerry L. Old, M.D.** **Leslie A. Newman, NP-C**

Danielle Tipton, LSCSW, LCAC **Indy M. Fairbanks, LSCSW, LCAC** **Sharon Shepard, LSCSW**

221 West 8th – P.O. Box 643

Winfield, Kansas 67156

620-221-3350

The undersigned hereby authorizes you to discuss with, disclose or prepare and furnish a report of my medical condition(s), which may include any condition or care related to drug and/or alcohol dependency, psychiatric or psychological diagnosis, or HIV or AIDS status to the specified family members: _____

_____

and also permit such person(s) to examine and receive a copy of any documents, records, pictures, or x-rays, under your control.

The information disclosed under this authorization may be subject to redisclosure by the recipient and will no longer be protected against disclosure.

It is acknowledged that this authorization is subject to be revoked upon written request at any time from the person whom is giving the authorization.

Printed Patient Name: _____ **Date Signed:**_____

Patient's Signature: _____

Or Signature of Representative and description of authority to act: _____

Patient's Date of Birth: _____ **SS#:**_____

Address: _____ **Phone #:**_____

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IN COWLEY COUNTY, INC
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Statement of Patient Financial Responsibility – (D5)

Your care at the Community Health Center in Cowley County (CHCCC) is a partnership between you and the staff of the Clinic. We rely on the fees paid by you and your insurance company to keep the Clinic operating. A copy of the Patient Bill of Rights and Responsibilities is available so that you will know the key elements of the partnership.

You are responsible for your bill. If you have insurance, CHCCC will bill your insurance company. Those payments will be applied to your account. The health center may serve patients with third party insurance that does not cover or only partially covers fees for certain health center services. These patients may also be eligible for Sliding Fee Discounts (SFDS) based on income and family size. In such cases, subject to potential legal and contractual limitations, the charge for each SFDS pay class is the maximum amount an eligible patient in that pay class is required to pay for a certain service, regardless of insurance status.

If you qualify for the Sliding Scale Discount, your discount will be set based on federal guidelines for family size and income. The sliding scale discount calculates your fair share of the cost of your care. You are expected to pay your portion of the charges.

For Patients with Insurance:

( ) I understand that CHCCC will bill my insurance company. I agree to pay my co-payment and required deductible at the time of service and to pay for services not covered by my insurance plan.

_____ Date_____
Signature

_____
Printed Name

For Patients with No Insurance:

( ) I agree to apply for payment assistance as recommended by the CHCCC staff. I understand that failure to complete the process will result in my being responsible for all charges. I agree that I will pay all charges for which I am responsible at the time of service or make payment arrangements with the Reception Manager. I understand that if I fail to pay my bill, I may be suspended and/or dismissed as a patient of the clinic.

_____ Date_____
Signature

_____
Printed Name

For All Patients:

I understand that I am responsible for my bill. I have read the above information and have no further questions.

_____ Date_____
Signature

_____
Printed Name

CHCCC will attempt in every way to work with the patient or legal guardian to satisfy the any debt. Please contact our office at (620) 221-3350 if you are unable to make a schedule payment. CHCCC can accept cash, check, money order or credit/debit (except American Express). We do accept debit/credit card payments over the telephone. Please mail payments to:

Community Health Center in Cowley County
P.O. Box 643
Winfield, KS 67156
620-221-3350

Community Health Center in Cowley County, Inc.

Westside Clinic - Winfield

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Patient Portal Authorization Form Purpose of this Form

The Patient Portal is designed to improve physician and patient communication. Once you are registered as a patient and have provided us with your secure email you will be assigned a username and temporary password. After you registered with the Patient Portal you will be allowed the following:
Update your contact information
Communication of laboratory results from staff to patient
Request prescription refills (no controlled medications)
View your medical summary, medication list, treatment history and visit dates
Receive reminders through your email
View current and past statements

The following will NOT be accepted through Patient Portal:
Receiving advice on the best course of treatment for your medical problem. All diagnosis will be made by your provider when you are seen for an office visit.
Request for narcotics/controlled medications.
Request for refill for medication not currently being prescribed by a Community Health Center Provider.
Online communications should never be used for life threatening, emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact 911 or your physician via telephone.

Reminders for Patient Portal:
You will have 5 failed log in attempts before the account is locked.
You will be receiving reminders via email from reminders@eclinicalmail.com regarding your appointments, test results posting etc. Please make security adjustments to your email or computer to receive our emails. You will not be able to reply to our email reminders from reminders@eclinicalmail.com. If you have any questions regarding these emails please send us a message via Patient Portal.
If you forget your password you may request another one through Patient Portal by clicking on the "Forgot Password" link.
After you are finished accessing Patient Portal be sure to logout and close your browser. This reduces the risk of someone else accessing your private information.
Avoid using a public computer to access Patient Portal.
Patient Portal is provided as a courtesy service for our patients. There is no service fee. However, if the patient abuses or misuses Patient Portal we reserve the right to terminate the patient's account.
Our hours of operation are 8:00 am - 5:00 pm Monday-Friday. We encourage you to use the web site at any time; however, messages are held for us until we return the next business day. Messages are typically handled within 2 business days. If your doctor is out of the office, your request may be held until your doctor returns to the office.
We reserve the right to suspend or terminate the patient portal at any time and for any reason.

How the Secure Patient Portal Works:
A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

You can access your health records through the Healow mobile app. Download the free Healow App from Apple App Store or Google Play.

If you need any assistance with the patient portal or the app, please let us know.

Patient Portal Authorization Form Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect. We will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: 1) The secure message must reach the correct email address, and 2) Only the correct individual (or someone authorized by that individual) must be able to have access to the message. Only you can make sure these two factors are present. It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided.

Secure Email Address: _____

Print name: _____ DOB: _____

Patient Signature: _____ Date: _____

Complete the following if the email address does not belong to the patient

Please note, portal access is available by proxy for children under 17 years of age or elderly patients.

Name of Parent/Guardian/Proxy requesting access

_____

Signature of Parent/Guardian/Proxy:_____

Relationship to the Patient_____Date:_____

Our Patient Portal site may be accessed by two different URL's. Our Website: www.creeksidemed.com

Patient Portal direct site: https://mycw106.ecwcloud.com/portal14556/jsp/100mp/login.jsp

Opting Out of Patient Portal

____ I am not interested in the patient portal at this time.

____ I do not have an email address.

____ I do not have a computer.

I understand that I can Opt In at any time in the future by contacting Community Health Center in Cowley County.

Print name: _____ DOB: _____

Patient Signature: _____ Date: _____

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Telehealth Informed Consent

I, _____, (name of patient) hereby consent to participate in telehealth services with Community Health Center in Cowley County providers as part of my treatment. I understand telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a provider and a patient who are located in two different locations.

I understand the following with respect to telehealth:

1) I understand I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand in the event of a crisis/emergency situation where my safety or others' safety is in jeopardy, I or my provider will call 911 immediately.

3) I agree to only use electronic communication with my provider(s) during their scheduled work days/hours. I further understand my provider will not read communications from me nor respond to me outside of regularly scheduled work hours.

4) I understand messages will be replied to within 24 hours or on my provider's next scheduled day of work (in the event of weekends, holidays and vacation, sick leave, etc.).

5) I understand there are risks and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies. If this occurs, end and restart the session. If technical difficulties arise and services is interrupted, try to reconnect. If unsuccessful, please call 620-221-3350 to continue/re-schedule.

6) I understand there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; physical/mental/emotional health as an issue in a legal proceeding, etc.).

7) I agree not to share my provider(s)' electronic contact information with anyone without first obtaining permission from the provider to do so.

By signing my name below, I indicate: I have read the information provided above. I understand the information contained in this form and any questions I have will be discussed with my provider. I understand the risks of communicating through electronic devices. I hereby authorize my provider(s) and Community Health Center in Cowley County staff to contact me electronically.

_____ _____
Signature of client/parent/legal guardian Date

_____ _____
Signature of provider Date

Much of the information contained in the form was obtained from NASW. CHCC March 24, 2020

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COMMUNITY HEALTH CENTER IN COWLEY COUNTY, INC

PO Box 643
Winfield, KS 67156

Patient Assistance Program – Sliding Fee Discount Application & Eligibility Form – (D1)

It is necessary for us to ask personal questions in order to give you a discount on our medical expenses. This information will be kept on file in our center in strict confidence. You must verify your income at least every six months. Your yearly income tax return with a copy of your W-2 form, a payroll check stub covering the past six months, or copies of your social security checks, or other checks you may receive will be sufficient proof. Your annual income will be used to calculate the level of your payment.

Name:
Address:
City, State:
Zip Code:
Telephone:
Social Security #:
Date of Birth:
Chart Number:

Today's Date:

Number of people living in your home:

What is your marital status?

☐ Married ☐ Widow(er) ☐ Single ☐ Divorced ☐ Separated

Place of employment for application?

Place of employment for spouse?

Place of employment for other person(s)?

HOUSEHOLD INFORMATION MUST BE COMPLETED FOR ALL APPLICANTS
(Provide Names, DOB and SSN of ALL individuals living in the household)

Name:	Date of Birth:	Social Security Number:

DOES YOUR HOUSEHOLD RECEIVE ANY OF THE SOURCES BELOW, AND IF SO, HOW MUCH?

Sources	You	Your Spouse	Your Children	Other Person	Total Sources
Social Security					
Public Assistance					
Retirement Pension					
Rental Income					
Interest Income					
Child Support, Alimony					
Other (Specify)					
Wages – Monthly Income (circle one) Daily Weekly Biweekly Monthly					

SELF-DECLARATION OF INCOME WILL BE ACCEPTED ON THE *FIRST VISIT ONLY*. ALL SUBSEQUENT VISITS WILL BE CHARGED AT THE FULL FEE UNLESS PROOF OF INCOME IS PROVIDED.
(Please select one of the following)

☐ **PROOF OF INCOME (Must be copied and attached to this application)**

☐ **SELF-DECLARATION (The following *THREE sections* must be completed ONLY if no proof of income is attached)**

Affidavit: By my signature below, I attest that the information provided herein is complete and accurate; that as of the date of my signature, the income sources listed constitute all of my household income, and the household members listed are solely dependent on that income. I understand that I may be required to provide additional information and documentation upon request by the CHCCC Patient Assistance Services Program for determining eligibility to participate in the discount program. I agree to inform CHCCC of any changes of condition or circumstance that might affect my eligibility to participate in the discount program. I also understand any untruthful or fraudulent information provided may be grounds for denial of future assistance.

Signature: _____

Printed Name: _____

Date: _____

Office Use Only:

Medical/Dental/Behavioral Service Discount:

[ ] Nominal Fee

[ ] 25% Fee

[ ] 50% Fee

[ ] 75% Fee

[ ] No Discount

DISCOUNT VALID UNTIL: _____

RECEPTION MANAGER/BILLING SPECIALIST SIGNATURE:

_____

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Patient Assistance Program – No Income: Financial Support and Affirmation of Identity Form – D(3)

Date: _____

Patient Name: _____

Please be advised that the above named patient has informed us that he/she currently does not has a stable source of income and that you are supporting him/her financially. Would you please complete the following information to verify that this information is correct so that we may be able to continue the patient's medical/dental care?

1. Does this patient live with you? ☐ Yes ☐ No If yes, please verify the address:

_____
Address City State ZIP

2. Do you provide food and clothing for this patient? ☐ Yes ☐ No

3. Several of our Patient Assistance Programs require proof of household income. Are you willing to provide that information so that we may be fully able to assist the patient?
☐ Yes ☐ No

Please provide the following information in the event we may need to contact you for further information.

_____
Name

( ) _____ ( ) _____
Home Work

By my signature below, I attest that the information provided herein is complete and accurate. I understand that I may be required to provide additional information and documentation upon request by the CHCCC Patient Assistance Services Program for determining the above named patient's eligibility to participate in the discount program. I agree to inform CHCCC of any changes of condition or circumstance that might affect the above named patient's eligibility to participate in the discount program. Any untruthful or fraudulent information provided may be grounds for denial of assistance to the patient.

_____ _____
Signature Printed Name