Community
CARE MINISTRIES

CLIENT ID: _____

NUMBER IN HOUSEHOLD: _____

Client Information

Last Name (please print) _____ First Name _____ M.I. _____ Date of Birth _____ Age _____

Physical Address (Not P.O. Box) _____ City _____ County _____ Zip Code _____

Previous Address (if less than 3 months) _____ City _____ County _____ Zip Code _____ State _____

May we email you? _____ Email: _____ Phone: _____

SSN: _____ Gross Monthly Income $_____

How did you learn about Community Care Ministries? _____

U.S. Citizen	Legally Disabled	Veteran	Gender	Ethnicity	Race
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Male ☐ Female ☐ Transgender	☐ Hispanic ☐ Non-Hispanic	☐ Native American ☐ White ☐ African American ☐ Asian ☐ Other

Marital Status	☐ Single	☐ Married	☐ Divorced	☐ Widowed	☐ Cohabitating
Employment Status	☐ Full-time ☐ Part-time	☐ Stay-at-home parent	☐ Retired ☐ Student	☐ Disabled ☐ Unemployed	☐ Other

Insurance

Health	Yes No	Type	Doctors Name	
Dental	Yes No	Type	Dentist Name	

I certify that the information provided is accurate and complete and I understand that I must provide income verification in order to receive services from Community Care Ministries, a Charitable Provider under KSA 75-6120.

_____ _____

Patient Signature Date

_____ _____

Signature of Parent or Legal Guardian Date

What are your current living arrangements?

- ☐ Own home
- ☐ Renting
- ☐ Temporarily living with friends or relatives
- ☐ Homeless

What is your highest level of education completed?

- ☐ PreK – 6th
- ☐ 7th – 12th
- ☐ High School/GED
- ☐ College/Professional Training
- ☐ Other, please be specific: _____

List *all other* members in the household (*besides yourself*)

Full Name	Social Security #	M/F	Date of Birth	Relationship	Race	Veteran or Disabled	Health Insurance

Who should we contact in case of emergency?

Name: _____ Relationship: _____ Phone: _____

Income/Eligibility Verification

For all 'EMPLOYED' members of the household, please list MONTHLY income amounts

Name of Household Member	Gross Rate of Pay	Source of Income
	$ per **Month**	
	$ per **Month**	
	$ per **Month**	
Grand Total Amount:		

Benefit Sources	Amount per Month	Name of Household Member
Unemployment	$	
Social Security Retirement Income (SS)	$	
Social Security Disability Income (SSDI)	$	
Supplemental Security Income (SSI)	$	
Veteran's Disability Income	$	
Worker's Comp	$	
TANF/Cash Assistance	$	
Retirement/Pension	$	
Child Support	$	
Alimony/Spousal Support	$	
SNAP/Food Stamps	$	
Other	$	
Medicaid	Yes No	
Medicare	Yes No	
TFAP Commodities	Yes No	
Section 8/Public Housing	Yes No	
VA Medical Services	Yes No	
WIC	Yes No	
LIEAP (Seasonal)	Yes No	

Monthly Expenses

Credit Cards	$	Child Care	$	Clothing	$	Child Support	$
Education	$	Electricity	$	Entertainment	$	Food (Not Food Stamps)	$
Garnishments	$	Household Gas	$	Health Ins.	$	House/Car Ins.	$
Laundry	$	Legal	$	Medical	$	Mortgage	$
Prescriptions	$	Payday Loans	$	Rent	$	Retirement	$
Storage	$	Savings	$	Car Payment	$	Phone	$
Gas for Car	$	Car Repair	$	Taxes	$	Water	$
Sewer/Trash	$	Liquor/Tobacco	$	Pets	$	Internet/Cable	$
Total	$	**Total**	$	**Total**	$	**Total**	$
						Staff will total the expenses…. Grand Total	

Community
CARE MINISTRIES

ATTENTION CCM PATIENTS

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 essental to insure we meet these 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?

PATIENT NUMBER: _____

Community CARE MINISTRIES

MID AMERICA ASSISTANCE COALITION

CLIENT CONSENT AND RELEASE OF INFORMATION

MAACLink is a computer system that is used locally as a Homeless Management Information System (HMIS). Use of an HMIS is required by the US Department of Housing and Urban Development (HUD) for agencies that receive HUD funding. MAACLink is not electronically connected to HUD and is only used by authorized agencies. All MAACLink users have received confidentiality training and have signed strict agreements to protect clients' personal information and limit its use appropriately. A Privacy Notice is available at participating agencies. It provides details on how member agencies and their employees handle client information and data sharing. I give permission to Community Care Ministries to collect, access, and enter my personal and household information into the MAACLink computer system. I understand that the MAACLink system is shared with and used by authorized agencies in my community for the purposes of:

1. Assessing the needs of low-income, homeless or other people with special needs in order to give better assistance and to improve their current or future situations.
2. Improving the quality of care and service for people in need.
3. Tracking the effectiveness of community efforts to meet the needs of people who have received assistance.
4. Reporting data on an aggregate level that does not identify specific people or their personal information.

I understand that:

1. All agencies that use MAACLink will treat my information in a professional and confidential manner.
2. Signing this release form does not guarantee that I will receive assistance.
3. My information may be shared with a third party (utility provider, landlord, etc.) to process the service I have requested.
4. I have the right to a printed copy of my MAACLink file.

☐ (Optional) Check this box to give consent for your photo to be uploaded to MAACLink.

Client Name (Printed)	**Client Signature**	**Date**

Agency Representative Name (Printed)	**Agency Representative Signature**	**Date**

☐ Check this box if you were unable to obtain the client's signature and verbal consent was given in its place.

Each MAACLink agency will ask you to sign this form at least annually. If after you give consent you decide you no longer would like your information entered into MAACLink, please complete the Client Revocation Form. If you do not revoke this authorization, it will automatically expire on 1/1/2022 *or one year from the date you sign and date this form.*

Community
CARE MINISTRIES

Medical History

Name: _____ Date of Birth: _____

Pharmacy: _____

1. Are you allergic to:

Medications?	Yes	No	If so list: _____
Local anesthetics?	Yes	No	If so list: _____
Latex?	Yes	No	If so reaction: _____

2. Have you been seen by a medical doctor in the last two years? Yes No

   If yes, for what? _____

   Name of Doctor _____

3. Have you been hospitalized in the last 5 years? Yes No

   If yes when: _____

   Reason: _____

Immunization History

Last Tetanus Shot: _____ Last Pneumonia Vaccination: _____ Last Flu Shot: _____

Current Medications

Name	Dose	Frequency	Reason for Medication

Please circle any of the following you have had, or have at present

ADHD
Alzheimer's/Dementia
Anxiety/Depression
Bipolar Disorder
Epilepsy/Seizures
Panic Attacks
Schizophrenia/Psychosis
Allergies/Hay Fever
Asthma
Emphysema/COPD
Tuberculosis
Cancer: _____

Anemia
Bowel Problems
Heartburn Reflux
Stomach Ulcer
Thyroid Problems
Arthritis
Fibromyalgia
Chronic Pain
MRSA Infection
HIV/AIDS
Blood Transfusion
Hepatitis: _____

Liver Trouble
Diabetes
Urinary Infection
Kidney Stone
High Blood Pressure
Heart (Surgery, Disease, Attack)
Artificial Heart Valves
Bleeding/Clotting Problems
Artificial Joint (Knee, Hip, Shoulder)
Pacemaker
STD's
Other: _____

Social History

On average, how many alcoholic beverages do you consume per week? _____
Do you use tobacco products? Yes No

Surgical History

Operation	Surgeon	Date

Family Medical History

(Relationship and Date of Onset)

Cancer _____
Stroke _____
Bleeding/Clotting _____
Kidney _____

Heart Attack _____
Diabetes _____
Thyroid _____
Other _____

Female History

Are you pregnant: Yes No Due Date _____
Are you nursing: Yes No
Date of last menstrual period _____

Signature _____ Date _____

Community
CARE MINISTRIES

Patient Name: _____ Date: _____

Please answer the following questions regarding your smoking history.

1. Please check below what best describes your current situation regarding cigarette smoking and the approximate number of years you have smoked or did smoke before quitting.

[ ] I currently smoke (less than one year)
[ ] I currently smoke (1 -3 years)
[ ] I currently smoke (4 - 8 years)
[ ] I currently smoke (9 - 15 years)
[ ] I currently smoke (16 - 25 years)
[ ] I currently smoke (more than 25 years)
[ ] I used to smoke (less than 5 years)
[ ] I used to smoke (6 – 15 years)
[ ] I used to smoke (16 - 25 years)
[ ] I used to smoke (over 25 years)
[ ] I have only smoked a handful of times or less
[ ] I smoke very sporadically and/or on rare occasions
[ ] I have never smoked a single cigarette

2. How old were you when you smoked your first cigarette?

[ ] Less than 11 years old
[ ] 11 – 15 years old
[ ] 16 – 19 years old
[ ] 20 – 25 years old
[ ] Over 26 years old

3. If you currently smoke, are you interested in quitting? Y N

4. Please indicate your current age. _____

5. What is your birth assigned sex? M F

6. How soon after you wake up do you have your first cigarette?

[ ] Within 5 minutes
[ ] 6-30 minutes
[ ] 31-60 minutes
[ ] After 60 minutes

7. How many cigarettes (or other tobacco product) per day do you smoke? _____

8. How many other tobacco users live with you? _____

9. Are you exposed to secondhand smoke on a regular basis? _____

10. In a typical week, how many nights do you wake up and use tobacco? _____
11. On a typical day, how many caffeinated beverages do you drink (coffee, tea, energy drinks)? _____

12. Please check which kinds of tobacco you use now:
- [ ] Cigarettes
- [ ] Pipe
- [ ] Hookahs
- [ ] Cigars
- [ ] Little cigars
- [ ] Chew, Spit or SNUS
- [ ] E-cigarette/Vaping device
- [ ] Other_____

13. How long are you able to go without smoking or using tobacco? _____
When was that? _____

14. When was the last time you tried to quit smoking or using tobacco? _____

15. What tobacco treatment medications have you used in the past to stop smoking or using tobacco?
Please check all that apply:
- [ ] Nicotine patches
- [ ] Bupropion (also called Zyban or Wellbutrin)
- [ ] Nicotine gum
- [ ] Varenicline (Chantix)
- [ ] Nicotine lozenge
- [ ] Combination of any of these medications (ex: Patch + Lozenge)
- [ ] Nicotine inhaler
- [ ] Nicotine spray
- [ ] Other medication _____

16. If you have quit before, what things triggered you to return to smoking or using tobacco?
Please check all that apply:
- [ ] Stress
- [ ] Boredom
- [ ] Social situations
- [ ] Withdrawal symptoms
- [ ] Being around other smokers
- [ ] Weight problems
- [ ] Urges to smoke
- [ ] Drinking alcohol
- [ ] I don't know
- [ ] A crisis
- [ ] Other_____

17. What things do you like about smoking? _____

18. What reasons do you have now for wanting to quit? _____

19. What worries or concerns do you have about quitting? _____

20. Please list any spiritual or cultural issues that you would like us to know about that are important to your smoking or your quitting.

Community
CARE MINISTRIES

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge I have been offered a copy of Community Care Ministries Notice of Privacy Practices. **I certify that the information provided on this page is true and correct to the best of my knowledge.**

Print Client Name	Client Date of Birth
Signature of patient (or	Date
Relationship to Client	

Inter-Staff Waiver of Confidentiality

I understand that the goal of Community Care Ministries (CCM) is to maximize the overall health of its clients – body, mind, and spirit. To take a "whole-person approach", it is helpful to have authorization to allow verbal communication between CHM staff members. By signing below, I am waiving / giving up my right to confidentiality for coordinating my care. Staff members include Medical Doctors, Nurse Practitioners, Registered Nurses, Dentists, Hygienists, Social Workers, and Marriage and Family Therapists. Communication might also include the Social Department Supervisor and Executive Director of CCM. Each professional will use discretion in determining what information should be shared.

Other Agency Waiver of Confidentiality

I also give my permission to CCM to contact other agencies or organizations who are offering me services, to coordinate my care. I further authorize these agencies to release relevant information to CCM.

Mandatory Reporters

I understand that licensed professionals are **required to report** if:

- They have reasonable suspicion that there may be abuse or neglect of a child or of a dependent or elderly adult.
- A client communicates a threat of bodily injury to self or others; or
- A court order that information be provided, or testimony given.

Community Care Ministries
Patient Agreement and Treatment Policies

Eligibility

Community Care Ministries (known as "CCM") provides services to individuals who meet the following eligibility requirements:

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

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

Services

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

Medications

CCM is not responsible for the payment of patients' prescriptions. Samples may be given to patients to begin treatment at the discretion of the provider. Patients are responsible for obtaining any ongoing medications and the cost associated with each prescription. CCM does not use stock medications for ongoing distribution to its patients. Enrollment for various assistance programs through individual pharmaceutical companies may be available to patients for ongoing prescriptions.

Prescription Refills

Patients are responsible for notifying their pharmacy when they are in need of a refill. Patients should call their pharmacy no less than TEN (10) DAYS before a medication runs out. CCM providers will NOT prescribe controlled substances.

PAP (Prescription Assistance, Eligibility Required)

Patients are responsible for notifying CCM when they need a refill. Patients should call no less than THIRTY (30) DAYS before a medication runs out.

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 costs prior to the consultation appointment. The patient must also check to see if financial assistance is available.

Patient Attendance Policy

Patients are expected to notify CCM if they cannot keep a scheduled appointment. Notification of a cancelled appointment is to occur by 4 pm on the day prior for afternoon appointments. This will allow CCM to schedule patients on our waiting list.

No-Show Policy

This policy pertains to all CCM services. The first time a patient is a no-show, that patient will be required to speak with a Social Service person before another appointment to see a provider will be made. A second no-show will result in a 90-day suspension from CCM. A third no-show will result in the patient being dismissed from CCM. The no-show policy also applies to specialty care referrals.

Privacy Policy

All CCM 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

CCM 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.

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

_____ Community Care Ministries is not an insurance carrier. CCM operates under the KDHE 's Charitable Care Health Program and through the generous donations of volunteer medical providers.

_____ I will notify the clinic no later than one (1) hour prior to an appointment if I cannot keep my scheduled appointment. I understand that if I do not, I will be subject to CCM's "No Show Policy."

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

_____ I understand that I am expected to treat CCM staff and volunteers with respect. If I am uncooperative, verbally, or physically abusive, intoxicated, create an intimidating, hostile, disruptive or discriminatory work environment, or behave in an inappropriate manner as determined solely by CCM, I may be immediately dismissed as a patient from CCM at CCM's sole discretion.

_____ I understand that I am expected to be truthful with CCM 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 CCM serves individuals who meet the eligibility parameters. I understand that I am responsible for being truthful about my residency, income, and insurance status. If I provide false information, services I receive from CCM will be terminated.

_____ I understand that I am responsible for monitoring my prescriptions and that I need to contact the pharmacy no less than ten (10) days before my prescription runs out. If I am a PAP patient, I am responsible for contacting the clinic no less than thirty (30) days before my prescription runs out. I understand that if I contact the pharmacy within less than ten (10) days, or the clinic within less than thirty (30) days of my prescription running out, I am not guaranteed a refill before my medication runs out.

_____ I understand that CCM's Board of Director's policy is that NO prescriptions or refills for medications which are classified "Scheduled II, Scheduled III, Scheduled IV, Scheduled V" will be provided by physicians, nurse practitioners, or physician assistants.

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, CCM may terminate the services I receive.

_____ _____

Patient/Client or Guardian's Signature Date

Community
CARE MINISTRIES

By signing below, I acknowledge that I have no health coverage, including Kansas Medicaid, Health Wave, Medicare, or any private insurance (including insurance with high deductibles). I will notify CCM immediately if I obtain any health benefits. I understand that once I am covered under a health coverage plan that I am no longer eligible to receive services at CCM.

_____ _____

Patient/Client or Guardian's Signature Date

By signing below, I give CCM 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/Client or Guardian's Signature Date

Community
CARE MINISTRIES

MEDICAL INFORMATION RELEASE FORM
(HIPAA RELEASE FORM)

Date: _____

Name: _____ Date of Birth: _____

RELEASE OF INFORMATION

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

- ☐ Spouse: _____
- ☐ Child(ren): _____
- ☐ Other: _____
- ☐ Information is not to be released to anyone

This **Release of Information** will remain in effect until terminated by me in writing.

MESSAGES

Please call: ☐ my home: _____ ☐ my work:_____ ☐ my cell: _____

If unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call
- ☐ _____

Best time to reach me is: (day) _____ between (time) _____

- ☐ You may send me information via email email address: _____

Signed: _____ Date: _____

Witness: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE - 9

(PHQ-9) Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
FOR OFFICE CODING (ADD COLUMNS) TOTAL SCORE: _____	____	____	____	____

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

GAD – 7

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3
FOR OFFICE CODING (ADD COLUMNS) TOTAL SCORE: _____	____	____	____	____

Community Care Ministries

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect December 15, 2006 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information we maintain, including health information we created or received before we made the changes. Before we make significant change in our privacy practices, we will change this notice and make the new Notice available upon request.

You may request a copy of our Notices at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and health care operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may also disclose certain health information for the purpose of obtaining follow-up care.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health care information or disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or to the health or safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody, the protected health information of an inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders as voice mail messages, postcards or letters.

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies we will charge you $0.10 for each page and $16.00 per hour for staff time to locate and copy your health information and postage if you want your information mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the past 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and must explain why the information must be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about the privacy practices or have questions or concerns please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Telephone: 785-456-7872
Address: 407 Ash St. Wamego, KS 66547