Community Health Center of Southeast Kansas

WELCOME!

Thank you for choosing the Community Health Center of Southeast Kansas, Inc. (CHC/SEK) for your healthcare needs. We are a patient-owned and patient-operated health care system established in 2003 to deliver healthcare the way it should be – affordable, accessible and accountable. CHC/SEK is a not-for-profit organization with all income invested back into our services, facilities, patients and staff. We believe quality healthcare is a right to which everyone is entitled and to support this, no one is ever denied care because of inability to pay.

Each of our clinics are designed and staffed to meet the needs of their community. However, we do all share a common purpose and mission and regardless of location and size have several things in common including...

*CHC/SEK is one of only 13,000 practices in the nation recognized by the National Quality Assurance Committee as a Patient-Centered Medical Home meaning our patients have high quality care when and where they need it and in a way they understand it. Additional information on what this means to you is enclosed.

*Services are available at times that meet our patient's needs including weekends and evenings. After hours, a medical and dental provider is on-call and can be reached by calling 620-249-5266 (Medical) and calling 620-249-5286 (Dental). These numbers are also posted on the outside of our buildings and our telephone message system.

*Patients – with and without insurance – may be eligible for discounted services based on their income and family size. More information on eligibility and applications for assistance are available with this welcome packet, in our clinics at Check-In or on our website at www.chcsek.org.

*We want to make sure our patients completely understand their care and provide interpretation and translation services, as well as signers for those with hearing limitations. Please let us know your needs when scheduling an appointment.

*In addition to health care, CHC/SEK works to make sure you have access to resources you may need including low-or-no-cost medications, transportation, assistance filling out applications for medical assistance and or the insurance marketplace and care coordinators to help you manage your care. To learn more, please contact the Patient Navigator or the Practice Manager or by calling 620-231-9873.

*To ensure our providers are the best, we require all licensed personnel to undergo a strict review process to verify their education, training and experience. Their performance is evaluated annually and compared to others across the nation with CHC/SEK providers some of the most outstanding in their field.

Any questions or concerns? Call 620-231-9873 and someone will direct your call to the person who can help.

What You Need to Know About
The Patient-Centered Medical Home

It is as good as it sounds. All care centers on you and is delivered by a "team" of health professionals working with and for you. Together, they provide the information needed to make decisions about your health and connect you to resources important to improving quality of life. These health providers use the most up-to-date information on the prevention of medical problems, the diagnosis and treatment of diseases and wellness efforts that make a difference.

It covers the whole person. CHC/SEK recognizes that the mind and the body are connected and provides access to medical, dental and mental health care for all of its patients regardless of financial status. Your state of mind impacts how you feel physically and our patient care teams include specialists in behavioral health who can offer suggestions on how to deal with chronic disease or challenges that most of us face throughout our life.

Care is coordinated. With your assistance, staff will connect you to the care you need and help you navigate through the healthcare system. Your Care Team serves as your advocate helping limit the confusion that can arise when you are in an unfamiliar place with providers that you don't know. We can also assist you with understanding your health insurance or obtaining affordable healthcare coverage. Trained staff is available at all clinics to help you sort through your options.

We follow you. When it's necessary to see a specialist or be hospitalized, your care team will make sure that those we refer you to have your health information so tests won't have to be unnecessarily repeated. Afterwards, we will follow up to make sure we have the results of these visits so we know what's been recommended.

What you tell us is important. We listen closely to what you have to say and we ask that you tell us as all you can about your healthcare needs. We need a complete medical history including all medicines (even those that don't require a prescription) and what other doctors you've seen. All information you give us is confidential and only asked to make sure that we have what we need to provide you comprehensive care.

It is available when you need it. CHC/SEK clinics offer services designed around school, work and family schedules. See the enclosed listing of all of the CHC/SEK clinics, their hours of operation and how to reach them. We also have a medical and dental provider on call when our clinics are closed and contact information is also included.

Everyone is treated equally. We are committed to providing *everyone* we serve with the right care at the right time. All of our resources and services are available to all patients regardless of income and are designed to be affordable for all.

The Community Health Center of Southeast Kansas is recognized by the National Committee for Quality Assurance as a Patient-Centered Medical Home.

Community Health Center of Southeast Kansas

QUALITY, ACCESSIBLE, AFFORDABLE HEALTHCARE
for the ENTIRE FAMILY

- **Primary medical, dental and behavioral services for adults & children.**
- **Medicare, Medicaid, KanCare & all insurance accepted with discounted rates available for those meeting financial guidelines.**
- **No one denied care due to inability to pay.**

Clinic Locations	Clinic Phones #	After Hours Phone # Leave a message and a provider will return your call.
Crawford County		
Pittsburg 3011 N. Michigan, Pittsburg, KS 66762	Main - 620-231-9873 Pharmacy - 620/231-2681 Walk-In Care-620/240-5600	Medical - 620-249-5266 Dental - 620-249-5268
Pittsburg Dental 924 South Broadway, Pittsburg, KS 66762	620-231-6788	620-249-5268
Arma 601 E. Washington St., Arma, KS 66712	620-347-4033	620-249-5266
Cherokee County		
Columbus 120 W. Pine, Columbus, KS 66725	620-429-2101	620-249-0739
Baxter Springs 2990 Military Ave., Baxter Springs, KS 66713	620-856-2900	Medical - 620-249-0739 Dental - 620-249-5268
Montgomery County		
Coffeyville 801 W. 8th St., Coffeyville, KS 67337	620-251-4300	Medical - 620-249-7296 Dental - 620-249-5268
Independence 3751 W. Main St., Independence, KS 67301	620-577-2131	Medical - 620-249-7296 Dental - 620-249-5268
Labette County		
Parsons 2100 Commerce Dr., Parsons, KS 67357	620-717-4450	Medical - 620-687-0513 Dental - 620-249-5268
Allen County		
Iola 2051 North State St., Iola, KS 66749	620-380-6600	Medical - 620-687-2889 Dental - 620-249-5268
Bourbon County		
Ft. Scott – Main Clinic 401 Woodland Hills Blvd, Ft. Scott, KS 66701	620-223-8040	620-644-9048
Ft. Scott – Walk-In Clinic 1624 S. National Ave, Ft. Scott, KS 66701	620-223-8482	620-644-9048
Linn County		
Pleasanton 11155 Tucker, Rd, Pleasanton, KS 66075	913-352-8379	888-521-6005
Mound City 302 N. 1st. St., Mound City, KS 66056	913-795-8302	888-521-6005

Community Health Center of Southeast Kansas

Thank you for choosing Community Health Center of Southeast Kansas, Inc. (CHC/SEK) for your healthcare needs. Please note that all information provided by you will be kept strictly confidential in compliance with Federal privacy laws. If you have any questions or need assistance, please ask the receptionist or call 620-231-9873. *Please complete this form in ink.*

PATIENT INFORMATION

Full Legal Name (Print)

Last Name:	First Name:	Middle Name:

Mailing Address_____ City _____

State_____ Zip Code_____ E-Mail Address_____

Do you want to access your medical records electronically? ❑Yes ❑No

(If yes, you will receive an email, at the email address listed above, from CHC/SEK with your log-in information and the log-in URL.)

Home Number_____ Cell Phone_____ Work Phone_____

Preferred method of communication for appointment reminders: ❑ Text ❑ Phone Call

Date of Birth_____ Male❑ Female ❑ Social Security Number_____

Marital Status:	**Employment Status:**	**Student Status:**
❑Divorced	❑Active Duty Military	❑Full-time Student
❑Married	❑Full-time Employment	❑Part-time Student
❑Partner	❑Part-time Employment	❑Not in School
❑Single	❑Self-Employed	
❑Widowed	❑Retired	
❑Legally Separated	❑Unemployed	

RESPONSIBLE CAREGIVER (Children under 18 years of age OR Adults with Durable Power of Attorney)
(Children under 18 years of age, please list two Responsible Caregivers)

Name:_____
Date of Birth: _____
Social Security Number: _____
Relationship to the Patient:_____
Mailing Address: _____
City, State, Zip: _____
Phone Number: _____

Name:_____
Date of Birth: _____
Social Security Number: _____
Relationship to the Patient:_____
Mailing Address: _____
City, State, Zip: _____
Phone Number: _____

(If Responsible Caregiver(s) is a foster parent or out-of-home placement, immediately produce appropriate paperwork illustrating placement and appropriate paperwork illustrating who maintains authority to make medical decisions on the patient's behalf).

Please Complete the Back of Form

EMERGENCY CONTACT

In the event of an emergency, who should we contact? _____
Relationship?_____
Home Number _____ Cell Phone_____ Work Phone _____

INSURANCE INFORMATION

Check all that apply:

❑No Health Insurance (Patient navigators are available to help determine if you are eligible for medical discounts or coverage)

❑KanCare (Amerigroup, Sunflower, United HealthCare) ❑Commercial Insurance
❑Other Medicaid ❑Medicare ❑Medicare Supplement
❑Motor Vehicle Accident ❑Workers Compensation ❑Other Accident

Provide insurance information below. Please provide the front desk with your insurance card for billing purposes.

Primary Insurance	**Secondary Insurance**
Insurance Plan_____	Insurance Plan_____
Member ID Number _____	Member ID Number _____
Group Number _____	Group Number _____
Policy Holder Information:	**Policy Holder Information:**
Full Name _____	Full Name _____
Date of Birth _____	Date of Birth _____
Social Security Number _____	Social Security Number _____
Relationship to Patient _____	Relationship to Patient _____
Employer _____	Employer _____

FINANCIAL INFORMATION (Please fill-out to help determine if you are eligible for medical discounts)

Persons In Family/Household: ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑Other_____
Estimated Annual Family/Household Income:_____

Race:
❑American Indian/Alaskan
❑Asian
❑Native Hawaiian
❑Black or African American
❑White
❑Other Race
❑Pacific Islander

Ethnicity:
❑Hispanic/Latino
❑Not Hispanic/Latino

Preferred Language:
❑English
❑Spanish
❑Other _____

Veteran
❑Yes
❑No

If you are Homeless, are you:
❑On the Street
❑Doubling Up
❑In Transitional Housing
❑In a Shelter
❑Other

Have you or has anyone in your household worked in agriculture, such as planting, cultivating, or harvesting (fruits, vegetables, grains, or dairy) in the last two (2) years as a:

❑Not Applicable ❑Seasonal Worker ❑Migrant Worker

Pharmacy:_____ _____
Name City & State

**Apothecare, physically located inside CHC/SEK's Pittsburg, Iola, and Fort Scott clinics, is CHCSEK's preferred pharmacy.

CONSENT FOR TREATMENT

PATIENT NAME (PRINT): _____ Date of Birth: ____/____/____

I, as the patient stated above or as the decision-maker for the patient stated above, am requesting healthcare services at Community Health of Southeast Kansas, Inc. ("CHC/SEK").

I understand that healthcare services may be provided by employees, agents, and independent contractors utilized by CHC/SEK, and that my information will be shared internally by CHC/SEK with one patient record.

While a patient of CHC/SEK, I consent and authorize CHC/SEK to provide healthcare services under the direction of CHC/SEK clinical professionals. I voluntarily consent to any examination, testing, or treatment by CHC/SEK clinical professionals as is necessary in their judgment for the patient.

I understand that no promise, guarantee, or warranty has been made regarding the result of any care provided to me by CHC/SEK.

I understand that all services at CHC/SEK shall be available without discrimination as prohibited by federal law and state law.

Blood/Bodily Fluid Exposure: If a professional is exposed to my blood or other bodily fluid, I consent to testing for Human Immunodeficiency Virus, Hepatitis, and/or other blood-borne illnesses. I understand that should such testing occur, I will not be billed for it.

Clinical Students: I understand that CHC/SEK is approved to train students from various healthcare fields, and that patients may be seen by clinical students unless I object in writing.

Clinical Photography: The use of clinical photography in some circumstances may be considered routine to patient care. Except in an emergency, I understand I:

- Will be informed prior to clinical photography of the use and purpose of the picture;
- Have the right to refuse clinical photography; and
- Have the right to withdraw consent for future clinical photography at any time.

Patient identification photos may be taken to ensure patient identity and for security purposes. Photos will be updated periodically and/or when my physical condition changes significantly.

FINANCIAL INFORMATION

Financial Agreement: I hereby assign to CHC/SEK any and all medical/dental/behavioral health benefits payable from any policy of insurance covering the patient (including but not limited to Medicare, Medicaid, Blue Cross/Blue Shield, etc.) to be paid directly to CHC/SEK to be applied to the charges for services rendered. I understand I am responsible for co-insurance payments, deductibles and/or any remaining balance. In the event prior-authorization for a treatment is required by any health plan or insurance policy, while CHC/SEK may assist in obtaining said prior-authorization, I remain ultimately responsible for obtaining said prior-authorization.

Patient Name: _____

Medicare/Medicaid: I understand that the information provided in applying for payment under Title XVIII or Social Security Act (Medicare), State Medicaid laws or any other federal or state entitlement program is correct and authorizes CHC/SEK or its employees or agents to provide medical or other information necessary for processing a claim to any government agency or their intermediaries or insurance carriers. I consent to CHC/SEK requesting payment of authorized benefits on my behalf.

Medicare and Medicaid Non-Covered Services: I understand that Medicare and Medicaid do not pay for some services. I understand that CHC/SEK will assist in the identifying of these services, and I also understand that I am fully responsible for payment of these identified services.

HEALTHCARE OPERATIONS ACTIVITIES

Federal law allows CHC/SEK to share your health information with specific organizations to improve communication between healthcare providers about your health and to increase the quality of care provided to you. These organizations may include other doctor's offices, hospitals, insurance companies, drug companies and others for the purposes of treatment, coordination of care, payment and other reasons related to healthcare operations. While your consent for sharing of information for this purpose is not needed, we do want you to be aware that your health information may be shared for this reason.

Patient Rights: I understand and have been provided a copy of CHC/SEK Patient Rights and Responsibilities.

Notice of Privacy Practices: I understand and have been provided a copy of the CHC/SEK Notice of Privacy Practices that include sharing information through the Kansas Health Information Network.

My signature below acknowledges that I have read and understand this document and am authorized to sign:

_____ _____

Signature of Patient or Decision-maker* Printed Name of Patient or Decision-maker*

*Relationship to Patient: ___Parent ___Legal Guardian
___Durable Power of Attorney ___Other/Relationship:_____
(Documentation is required at time of signing Consent for Treatment form)

Date(Month/Day/Year):_____/_____/_____

_____ _____

Signature of Witness Printed Name of Witness

Date(Month/Day/Year):_____/_____/_____

Community Health Center of Southeast Kansas

Financial Assistance Application

Community Health Center of Southeast Kansas, Inc. (CHC/SEK) provides quality health care to all, regardless of ability to pay. The information provided on this Financial Assistance application may qualify you for assistance if you have difficulty paying for services.

If you have any questions regarding your Financial Assistance Application contact:

CHC/SEK - Financial Assistance at (620) 240-5682 or fa@chcsek.org

Return your completed Financial Assistance Application to:

CHC/SEK – Financial Assistance, P.O. Box 1832, Pittsburg, Kansas 66762
Fax Number: (620) 231-2808 Email: fa@chcsek.org

You may deliver your application to ANY CHC/SEK clinic.

A completed Financial Assistance Application includes:

- ☑ A filled-out and signed Financial Assistance Application (please print clearly).
- ☑ All supporting documents (proof of income, proof of address).

You may qualify for Financial Assistance if you have health insurance; so, please complete the Financial Assistance Application regardless of your health insurance status.

CHC/SEK applies presumptive eligibility, which allows you to qualify for Financial Assistance while your Financial Assistance Application is being processed.

A determination on whether you qualify for Financial Assistance will be made within seven (7) days of the submission of your completed Financial Assistance Application.

Your Financial Assistance will last for one (1) year from approval of your Financial Assistance. After the year, you will be need to complete a new Financial Assistance Application.

Please see CHC/SEK's website, www.chcsek.org, for additional information on CHC/SEK's Financial Assistance Program.

Income Self-Declaration: No proof of my income is available. Given no proof of my income is available, I declare that my annual income is $_____ I have no proof of my income because _____.

Patient/Guardian Name (Print): _____

Patient/Guardian Signature: _____

Date: _____(Month)_____(Day)_____(Year)

Effective 2/1/14; Revised 8/2012, 5/2013, 7/2013, 3/2014, 7/2014, 3/2015, 12/2015, 3/2016, 3/2017, 4/2017, 7/2017, 2/2019

FINANCIAL ASSISTANCE APPLICATION FORM

Telephone: (620) 240 - 5682 Fax: (620) 231 - 2808 Email: fa@chcsek.org

Applicant Name(Print):_____Date of Birth: ____/____/_____ Phone Number: _____
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
Email Address: _____Health Insurance: ❑Yes ❑No (If Yes, please list any health insurance your family has.)
❑Medicare, ❑Medicaid/KanCare, ❑Commercial/Private, ❑Other: _____
Health Insurance Company Name: _____ Health Insurance Company Name: _____

Family Information: **Family Size (Including yourself):** ❑1, ❑2, ❑3, ❑4, ❑5, ❑6, ❑7, ❑8, ❑Other: _____

Name	Date of Birth	Name	Date of Birth
PATIENT (If different from applicant)		DEPENDENT	
SPOUSE/PARTNER		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	

Annual Family Income Information: Total income before taxes.

Family Member Receiving Income	Type of Income (wages, social security, pension, retirement, disability, child support, unemployment, etc.)	How Much	How Often (weekly, monthly)

Proof of Income: Please provide income documentation on all family members eighteen (18) years old or older. Proof of income is required to determine financial assistance. If you cannot provide *Proof of Income*, you may fill-out **Income Self-Declaration** on the bottom of the previous page.
Examples of Proof of Income: A "W-2" withholding statement; Current pay stubs (3 months); self-employment information; last year's income tax return; pension statements; Supplemental Security Income (SSI) information; unemployment benefits statements; written statements from employers.
Attestation: I declare the above information is correct and assume responsibility of contacting CHC/SEK should any changes to financial or insurance status occur. I understand that I will be disqualified from financial assistance for giving false information.

Patient/Guardian Signature: _____ Date: _____ (Month)_____(Day)_____(Year)

Effective 2/1/1 4; Revised 8/2012 , 5/201 3, 7/201 3, 3/2014 , 7/201 4, 3/201 5, 12/2015, 3/ 2016, 3/2017, 4/2017, 7/2017, 2/2019

CHC SEK Community Health Center of Southeast Kansas

CHC/SEK 2019 Schedule of Discounted/Nominal Charges				
DESCRIPTION	SLIDE A	SLIDE B	SLIDE C	SLIDE D
Medical				
	$15.00	$25.00	$35.00	$45.00
Dental				
	$35.00	$45.00	$55.00	$65.00
Mental Health & Addiction Treatment				
	$25.00	$35.00	$45.00	$55.00
Ultrasound, Doppler, Mammography				
	$50.00	$60.00	$70.00	$80.00
Care Management, DSMT, & Virtual Communication				
	$0.00	$1.00	$2.00	$3.00
Walk-In Clinic				
	$25.00	$35.00	$45.00	$55.00
Physical Therapy				
	$15.00	$25.00	$35.00	$45.00
Optometry				
	$25.00	$35.00	$45.00	$55.00
Hospital Services				
LIMITED ADMISSION	$35.00	$45.00	$55.00	$65.00
MODERATE ADM	$35.00	$45.00	$55.00	$65.00
COMP ADM	$35.00	$45.00	$55.00	$65.00
LIMITED DAILY	$25.00	$35.00	$45.00	$55.00
EXPANDED DAILY	$35.00	$45.00	$55.00	$65.00
DETAILED DAILY	$35.00	$45.00	$55.00	$65.00
DISCHARGE LESS THAN 30	$35.00	$45.00	$55.00	$65.00
DISCHARGE GREATER THAN 30	$35.00	$45.00	$55.00	$65.00
OBS LOW	$35.00	$45.00	$55.00	$65.00
OBS MOD	$35.00	$45.00	$55.00	$65.00
OBS DISCHARGE	$35.00	$45.00	$55.00	$65.00
DELIVERY	$666.00	$766.00	$866.00	$966.00
C SECTION FIRST ASSIST	$229.00	$279.00	$329.00	$379.00
DELIVERY OF PLACENTA	$76.00	$86.00	$96.00	$106.00
H & P NEWBORN	$74.00	$84.00	$94.00	$104.00
ATTEND AT DELIV	$61.00	$71.00	$81.00	$91.00
SUBS CARE NEWBORN	$19.00	$29.00	$39.00	$49.00
CRIT CARE LESS THAN 28 DAYS	$755.00	$855.00	$955.00	$1,055.00
CIRCUMCISION	$180.00	$190.00	$200.00	$210.00
SKILL ADM STABLE	$35.00	$45.00	$55.00	$65.00
SKILL ADM COMPL	$35.00	$45.00	$55.00	$65.00
SKILL ADM COMPREH	$35.00	$45.00	$55.00	$65.00
SKILL DAILY STABLE	$35.00	$45.00	$55.00	$65.00
SKILL DAILY CHANGES	$35.00	$45.00	$55.00	$65.00
SKILL DAILY COMPLICATIONS	$35.00	$45.00	$55.00	$65.00
SKILL DIS LESS THAN 30	$35.00	$45.00	$55.00	$65.00
SKILL DIS GREATER THAN 30	$35.00	$45.00	$55.00	$65.00
ANNUAL NURSING FAC ASSESS	$35.00	$45.00	$55.00	$65.00
SAME DAY ADMIT DIS LOW	$35.00	$45.00	$55.00	$65.00
SAME DAY ADMIT DIS MOD	$35.00	$45.00	$55.00	$65.00
SAME DAY ADMIT DIS COMP	$35.00	$45.00	$55.00	$65.00

Community Health Center of Southeast Kansas

Community Health Center of Southeast Kansas, Inc. (CHC/SEK)
Patient Rights and Responsibilities

Patient Rights: Patients can expect

- To be treated with dignity and respect;
- To a safe, sanitary environment that promotes privacy and dignity that is free from abuse, neglect, exploitation and restraint or seclusion of any form used as a means of coercion, discipline, convenience or retaliation;
- Treatment services free of discrimination based on race, religion, ethnic origin, national origin, evidence of insurability, sexual orientation, age, disability, medical condition, or ability to pay for services;
- To receive communication in a language the patient can understand;
- To receive information and education that is easily understood regarding their medical/dental/psychiatric condition, expected outcomes and treatment options, and prescribed medications, including side effects, risks and benefits. Patients in substance treatment should be informed if medication compliance is a condition of treatment and discharge plans for medications;
- To participate in the development of an individualized treatment plan with periodic review and revision, as appropriate, of said individualized treatment plan;
- To be able to refuse treatment or withdraw consent to treatment, unless such treatment is ordered by a court or is necessary to save the patient's life or physical health. Patients refusing treatment should be informed of possible consequences of that decision;
- To receive a referral to another program/service if CHC/SEK is unable to provide a service that the patient requests or as indicated in the assessment or treatment plan of the patient;
- That in the event CHC/SEK refers the patient to a provider and/or healthcare entity, outside of CHC/SEK, CHC/SEK will follow-up with said provider and/or healthcare entity to ensure continuity of care;
- To receive treatment recommendations and referrals, if applicable, if the patient is to be discharged or transferred;
- Privacy in treatment including the right not to be fingerprinted, photographed or recorded without consent, with the exception of photographing for identification/administrative purposes or video recordings used for security purpose;
- To receive assistance from a family member, designated representative or other individual in understanding, protecting or exercising the patient's rights;

- To be treated in the least restrictive environment and manner consistent with the patient's legal status and patient's clinical condition, and which preserves the patient's safety and the safety of other patients and CHC/SEK staff;
- To confidential, private communication including telephone calls, letters and personal visits with the patient's provider, attorney, clergy, Department of Aging and Disability Services, or other individuals unless restriction of such communication is clinically indicated and documented in the record;
- To consent in writing, refuse to consent, or withdraw written consent to participate in research, experimentation or a clinical trial that is not a professionally recognized treatment without affecting the services available to the patient;
- To be free from coercion in engaging in or refraining from individual religious or spiritual activity, practice or belief and to be able to practice their individual religious beliefs;
- The ability to exercise a grievance procedure to resolve differences and to receive a response to a grievance in a timely and impartial manner;
- Freedom from retaliation for submitting a grievance to CHC/SEK administration, the Department of Social and Rehabilitation Services, or another entity;
- The ability to obtain a copy of their medical record at the patient's expense;
- To be informed, at the time of registration or before receiving services, of any fees the patient is expected to pay, and of refund policies, except for treatment during a crisis situation;
- An explanation of the bill for services, information on payment options including financial assistance and/or access to sliding fees and counseling regarding other financial resources; and
- Confidentiality of medical, financial and personal information which will not be released to other parties without appropriate consent.

Patient Responsibilities include:

- Providing accurate, complete, and up-to-date information related to your health including present concerns, past illnesses and surgeries, hospitalizations and emergency room/urgent care visits, and medications;
- Showing respect to and consideration of the rights of other patients, CHC/SEK staff and providers, including respect for property;
- Providing information needed for insurance claims and working with staff to make payments and/or applying for reduced fees;
- Following your individualized treatment plan;
- Following CHC/SEK policies;
- Expressing concerns or complaints so they may be addressed; and
- If CHC/SEK staff is exposed to patient's blood or other bodily fluid, consenting to testing for Human Immunodeficiency Virus, Hepatitis, and/or other blood-borne illnesses.

Updated: 01/2016
06/2018

Community Health Center of Southeast Kansas

Notice of Privacy Practices

Your information. Your rights. Our responsibilities.

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

Your Rights

***When it comes to your health information, you have certain rights*.** This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

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

Request confidential communications

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

Ask us to limit what we use or share

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

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Get a list of those with whom we've shared information

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

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us:

  Privacy Officer/Compliance Officer
  3015 N. Michigan P.O. Box 1832
  Pittsburg, Kansas 66762
  Phone: 620-240-5015 email: dcreitz@chcsek.org
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

***For certain health information, you can tell us your choices about what we share*.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

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

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

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

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

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

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks your provider about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

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

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Comply with contracts with pharmaceutical companies and other suppliers

We can share health information about you for audit and other purposes.

Do research

We can use or share your information for health research.

Comply with the law

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

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

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

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

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

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

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Your Rights Regarding Health Information Technology

CHC/SEK participates in the electronic exchange of health information with other healthcare providers and health plans in the State of Kansas through an approved health information organization. Through our participation, your PHI (Personal Health Information) may be accessed by other providers and health plans for the purposes of treatment, payment, or health care operations.

Under Kansas law, you have the right to decide whether providers and health plans can access your health information maintained at a health information exchange ("HIE"). You have two choices. You can permit authorized individuals to access your PHI maintained at an HIE for treatment, payment, or health care operations. If you choose this option, you do not have to do anything.

You can choose to restrict access to your PHI maintained at an HIE by submitting the required form to the Kansas Health Information Exchange at http://www.khie.org. Your restriction does not prevent access to your PHI maintained by an HIE for purposes of obtaining information about certain communicable diseases or suspected incidents of abuse by authorized individuals. Your decision to restrict access of your PHI maintained at an HIE does not prevent permissible uses and disclosures of your PHI, outside of an HIE, by CHC/SEK as outlined in this notice. Additional information regarding electronic health information exchanges is available at http://www.khie.org.

Changes to the Terms of this Notice

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

Updated: 09/2013 03/2015 01/2019