KLAMATH HEALTH PARTNERSHIP

"Our mission is to provide accessible, culturally sensitive, affordable, quality-driven, patient-centered health services to the community, with an emphasis on the underserved."

SERVICES WE OFFER:

- **Medical**
- **Dental** (available at KOD and COD only)
- **Behavioral Health** (available at KOD and CCC only)
- **Transportation to and from appointments**
- **Assistance signing up for insurance at little or no cost to you**

ASK ABOUT OUR SLIDING FEE DISCOUNT

CONTACT PATIENT RESOURCES ABOUT:

- **DRUG ASSISTANCE PROGRAMS**
  Most pharmaceutical companies have available programs for free or reduced-cost medications. Our Patient Resources department assists patients in filling out and submitting the required applications to the pharmaceutical companies who offer these programs.
- **OREGON HEALTH PLAN**
  Our Patient Resources department assists patients in filling out and submitting applications for the Oregon Health Plan.
- **COMMUNITY RESOURCES**
  Our Patient Resources department assists patients in obtaining vital community resources.

CALL ☎ 541-880-2078 ASK FOR **Bianca Valadez** **Nia Hubble** **Dawn Wallace**

SERVING YOU AT 4 CONVENIENT LOCATIONS:

KLAMATH OPEN DOOR FAMILY PRACTICE	CHILOQUIN OPEN DOOR FAMILY PRACTICE	CONVENIENT CARE CLINIC	KLAMATH OPEN DOOR PHARMACY
2074 S. 6th Street Klamath Falls, OR 97601	103 S. Wasco Avenue Chiloquin, OR 97624	2684 Campus Drive Klamath Falls, OR 97601	2074 S. 6th Street Klamath Falls, OR 97601
Phone: 541-851-8110 **Fax:** 541-851-8114	**Phone:** 541-783-2292 **Fax:** 541-783-3160	**Phone:** 541-851-8110 **Fax:** 541-887-8392	**Phone:** 541-880-2094 **Fax:** 541-851-0190
Hours Mon-Fri: 7am – 6pm Saturday: 8am – noon Sunday: **CLOSED**	**Hours:** M, T, W, F: 8am – 6pm Thursday: 8am – 5pm Sat. & Sun: **CLOSED**	**Hours:** Mon-Fri: 11am – 8pm **Closed for lunch** 2pm-3pm Sat & Sun: **CLOSED**	**Hours** Mon-Fri: 8:30am – 6pm Sat. & Sun: **CLOSED**

Nurse Advice Line available for all locations after hours by calling 541-851-8110

Effective Date: 04/09/2020

NOTICE OF PRIVACY PRACTICES

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.

If you have any questions about this notice, please contact Kacie Whitehead (Klamath Health Partnership Privacy Officer) at (541) 851-8110

2074 South 6th St. Klamath Falls, OR 97601

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. Your health information may include information created and received by this office, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

- **For Treatment.** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

  For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

  Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

- **For payment**. We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party.

  For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will pay for the treatment.

- **For Health Care Operations.** We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care.

  For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

  We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

- **Appointment Reminders.** We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

- **Treatment Alternatives.** We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

- **Health-Related Products and Services.** We may tell you about health-related products or services that may be of interest to you.

  Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us **in writing** (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.

- **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

- **Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

- **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

- **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

- **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

- **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

- **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

- **Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

  In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as HIV, substance abuse, mental health, and genetic testing information.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to our Privacy Officer (Kacie Whitehead) in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies.

  We may deny your request to inspect and/or copy records in certain limited circumstances. If you are denied copies of or access to health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

- **Right to Amend.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

  To request an amendment, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM to our Privacy Officer.

  We may deny your request for an amendment if your request is not **in writing** or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - We did not create, unless the person or entity that created the information is no longer available to make the amendment
  - Is not part of the health information that we keep
  - You would not be permitted to inspect and copy
  - Is accurate and complete

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, and a limited number of special circumstances involving national security, correctional institutions and law enforcement. The list will also exclude any disclosures we have made based on your written authorization.

To obtain this list, you must submit your request **in writing** to our Privacy Officer. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

  To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION to our Privacy Officer.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy.

  To obtain such a copy, contact our Privacy Officer, Kacie Whitehead.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post the current notice *or a summary of the current notice* in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Kacie Whitehead, Privacy Officer at (541) 851-8110. ***You will not be penalized for filing a complaint.***

Klamath Health Partnership, Inc.
Notice about Nondiscrimination and Accessibility Requirements

Discrimination is Against the Law

Klamath Health Partnership, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex Klamath Health Partnership, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Klamath Health Partnership, Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Klamath Health Partnership, Inc. at 541-851-8110, daily from 7:00 AM to 6:00 PM.

If you believe that Klamath Health Partnership, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Evelyn Lowell, Compliance Officer
2074 S. 6th Street
Klamath Falls, OR 97601
1-877-672-8620
hr@kodfp.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, contact Customer Service at 541-851-8110, daily from 8:00 AM to 6:00 PM.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Klamath Health Partnership, Inc.

Language Access

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-541-851-8110

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-541-851-8110

繁體中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-541-851-8110

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-541-851-8110

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-541-851-8110 번으로 전화해 주십시오.

УКРАЇНСЬКА (Ukranian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-xxx-xxx-xxxx

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-541-851-8110 まで、お電話にてご連絡ください。

اللغة العربية/ ARABIC ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-541-851-8110.

ລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-541-851-8110.

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-541-851-8110

Français (French) ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-541-851-8110.

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-541-851-8110.

Română (Romanian) ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-541-851-8110.

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-541-851-8110

Kajin Majel (Marshallese) LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaaloḷọk 1-541-851-8110

ភាសាខ្មែរ (Cambodian) ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-541-851-8110

ကြမာနှန် (Burmese) သတိျပဳရန္ - အကယ္၍ သင္သည္ ျမန္မာစကား ကို ေျပာပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့္အတြက္ စီစဥ္ေဆာင္ရြက္ေပးပါမည္။ ဖုန္းနံပါတ္ 1-541-851-8110 သုိ႔ ေခၚဆိုပါ။

Klamath Health Partnership, Inc.

ACKNOWLEDGMENT AND CONSENT

I understand that ***Klamath Health Partnership Inc.*** (Referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to;

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various offices, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's **Notice of Privacy Practices** in effect will be posted in waiting/reception area and on our website at: www.klamathopendoor.com

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____ Date: _____
(Patient)

-OR-

By: _____ Date:_____
(Patient representative)

Description of Representative's Authority: _____

PATIENT AGREEMENT FORM

Please initial in each box

☐ **CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE**: We will collect your co-payment or sliding fee arrangement at the time of each appointment. Also, payment must be made in advance for any elective services that are not covered by your insurance, or if the deductible has not been met, before the procedure will be scheduled. It is necessary to speak with the billing office to establish payments.

☐ **MEDICATIONS**: Please bring a list of your medications and vitamins or the bottles of all medications and vitamins that you are currently taking to the first appointment with your provider.

☐ **PLEASE NOTE:** Some medications are under the surveillance of the Drug Enforcement Agency, including opiate pain medications (such as Vicodin, Oxycodone, Methadone) and benzodiazepines (Ativan,Valium,Xanax, and Klonopin). ***By clinic policy, our providers will not refill these medications at your first visit with our clinic.*** If you are on a medication such as this on a continuous basis, please obtain a refill from your prior medical provider to cover you until your second appointment at our clinic.

☐ **PRESCRIPTION REFILLS**: Call your pharmacy for all prescription refills and the pharmacy will contact our office for a refill. Even if there are no refills left, the pharmacy will contact our office for authorization. Those prescriptions requiring a hard copy to be hand carried to the pharmacy can be picked up at the clinic. Our clinic policy is that providers must review and confirm medical records prior to prescribing medications to the patient.

☐ **CHECK-IN TIME**: You are expected to check in 15 minutes prior to your scheduled appointment time.

☐ **Late Arrival**: If you are more than 10 minutes late to your appointment, the appointment may need to be rescheduled. This is to ensure that the patients that arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comers as best as possible, but cannot compromise on the quality and timely care provided to our other patients.

☐ **CANCELLED APPOINTMENTS:** We require a 24-hour notice when cancelling your appointment.

☐ **FAILED APPOINTMENTS:** A late cancellation is considered a failed appointment.

☐ **NEW PATIENTS:** New Patients that fail to attend **2** New Patient appointments without cancelling 24 hours in advance will no longer have the opportunity to schedule further appointments at Klamath Health Partnership, Inc. clinics.

☐ **ESTABLISHED PATIENTS:** Established patients that fail to attend 3 appointments without cancelling 24 hours in advance within a 12 month period will be dismissed from the practice and no longer able to schedule appointments at Klamath Health Partnership, Inc. clinics.

☐ **INSURANCE BILLING:** Please provide us with complete and accurate insurance information at every appointment, as well as any changes in your address, telephone number and employer. We accept all commercial insurances, Medicare and Medicare Advantage plans, and Oregon Health Plan managed care plans including Cascade Comprehensive Care. We do not accept any Medicaid insurance programs through other states or counties.

☐ **NON-INSURED:** Our clinic offers a sliding scale fee based on your annual income to discount the charges for our services. X-rays will not slide.

☐ **SLIDING SCALE FEE:** All of our patients can apply for this program even those with insurance coverage. You are required to fill out and sign the income verification form and return to the registration desk with acceptable proof of income to qualify for this program. The scale which you qualify at depends upon your annual income. You are required to re-apply for the sliding scale annually or whenever your income changes.

☐ **LABS:** The majority of lab specimens collected in our lab are sent out to InterPath Laboratory to run the tests. InterPath bills separately for its services and uses a separate sliding scale for their charges. If you have any questions about your lab bill please contact InterPath directly.

☐ **REMINDER CALLS:** With my consent, KHP may call my home or other designated location and leave a message reminding me of my appointments. Please provide the appropriate contact numbers and PLEASE let us know if you DO NOT want to be contacted.

☐ **PBM Consent:** Prescription Benefit Manager allows prescribers to obtain critical patient drug information during the time of the office visit.

Klamath Health Partnership Inc.

PATIENT REGISTRATION FORM

Date: _____

PATIENT INFORMATION:

☐ Patient is a minor

☐ Patient will be paying cash for services

☐ Patient is the Primary Insurance Policy Holder

☐ Patient is the Person Responsible for this account

Name: _____Middle Initial: _____Last Name: _____

Address: _____City, State, Zip code: _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Patient Age: _____ Patient **SSN**: _____

Pharmacy of Choice: _____

GUARANTOR ACCOUNT/ RESPONSIBLE PARTY INFORMATION (Do Not State Insurance):

☐ Person Responsible is the Primary Policy Holder ☐ Patient is the Person Responsible for this account

☐ Person Responsible is the Secondary Policy Holder ☐ Person Responsible will be paying cash for services

Legal Name: _____

Address: _____City, State, Zip code: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

Responsible Party's Date of Birth: _____Responsible Party SSN: _____

EMERGENCY CONTACT

Name: _____Relationship_____

Address: _____

Home #: _____Cell # _____Work: _____

Klamath Health Partnership, Inc.

We have to ask....

Klamath Open Door is a Federal Qualified Clinic; we are required to obtain the following information for government reporting purposes. Please be assured all information is unidentified and is kept strictly confidential.

Patient's Race:

☐ White ☐ Black/African American ☐ Asian

☐ Native Hawaiian ☐ Pacific Islander ☐ Alaska Native

☐ Native American ☐ Other: _____

Patient Ethnic Background:

☐ Hispanic ☐ Not Hispanic ☐ Other: _____

Patients Primary Language:

☐ English ☐ Spanish ☐ Other: _____

Is the patient a migrant or seasonal worker?	Yes	No
Is the patient a dependent of a migrant or seasonal agriculture worker?	Yes	No
Is the patient homeless?	Yes	No
Is the patient a Veteran?	Yes	No

Do you wish to apply for the discounted fee program? Yes No

If Yes: Please complete the Sliding Fee Program application Form attached. Please provide proof of income within 30 days for everyone in your household who earns or receives income. (Information is in the back of the sliding fee form)

If No: Please check your total household income level below. No additional information is needed.

Total number of persons in Household: _____

Total household income per year:

☐ Under $12,760

☐ $12,761-$16,971

☐ $16,972-$21,182

☐ $ 21,183- $25,519

☐ Over $25,520

Patient Information Questionnaire

(Please complete for patients 18 years and older)

Our electronic health record has been updated recently to include a few new questions. You only need to complete the questionnaire once, unless there is a change. You are welcome to update us at any time. These questions may seem personal, but they help us understand the population we are serving.

1. What gender were you assigned at birth, on your birth certificate?
   - ❑ Male
   - ❑ Female

2. How do you describe yourself?
   - ❑ Male
   - ❑ Female
   - ❑ Transgender male/Trans man/Female-to-male
   - ❑ Transgender female/Trans woman/Male-to-female
   - ❑ Genderqueer, neither exclusively male nor female
   - ❑ Other, please specify: _____
   - ❑ Choose not to disclose

3. Do you think of yourself as:
   - ❑ Straight or Heterosexual
   - ❑ Lesbian, Gay, or Homosexual
   - ❑ Bisexual
   - ❑ Other, please specify: _____
   - ❑ Don't know
   - ❑ Choose not to disclose

We thank you for your participation! As a Community Health Center we are asked to provide information on the population we serve. This helps identify resources that may be able to assist our community and its needs. This information can also help your Medical Provider fully understand all of your clinical needs. This information is confidential.

Klamath Health Partnership Inc.

ASSIGNMENT OF BENEFITS

(Permission to bill your Insurance)

Name of Policy Holder: _____

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Policy Holder's SSN: _____ Policy Holder's Date of Birth:_____

Employer: _____Address/ City/ State/ Zip Code: _____

Name of Insurance Company: _____ Phone: _____

Policy Number: _____Group Number: _____Effective Date: _____

Patient's Name: _____

I hereby instruct and direct _____Insurance Company to pay by check made out and mailed to:

KLAMATH HEALTH PARTNERSHIP
2074 S 6TH STREET
KLAMATH FALLS, OR 97603

OR

If my current policy prohibits direct payment to doctor/ dentist, I hereby also instruct and direct you to make out the check to me and mail it to: **KLAMATH HEALTH PARTNERSHIP 2074 S 6th Street, Klamath Falls, OR 97603,** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE POLICY.** This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of the Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at *Klamath Health Partnership Inc.*

_____ _____

Signature of Policyholder and Date **Witness and Date**

Signature of Claimant, if other than Policyholder_____Date_____

PATIENT ID: _____

Klamath Health Partnership

Income Verification Form

(If applying for the Sliding Scale)

Patient Name: _____

DOB: _____SSN:_____ Phone Number:_____

Guarantor Name: _____
(Person responsible for charges and is not the patient)

Address: _____

DOB: _____SSN:_____

Please list the members of your household:

Name	Date of Birth	Income
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list the household income received from the following sources:

	Amount:	How Often:
Employment	$ _____	_____
Unemployment Compensation	$ _____	_____
Workers compensation	$ _____	_____
SSD/SSI	$ _____	_____
Child Support	$ _____	_____
Food Stamps	$ _____	_____
Social Security Retirement Benefits	$ _____	_____
Retirement/Pension	$ _____	_____
Student Loans or Financial Aid	$ _____	_____
Bank (checking or savings)	$ _____	_____
TANF	$ _____	_____
Other: _____	$ _____	_____

PATIENT ID: _____

Klamath Health Partnership

If you have not worked nor have any income from the sources listed, please provide us with your work source letter from the employment office. Please explain how you have been meeting your basic living expenses.

_____
_____
_____
_____
_____

Documents that will be requested in order to verify your income may include:

- Worker's Compensation
- W-2 Forms
- Income tax returns
- Social Security notice/income
- Pension notice
- College students; parent's income/ educational assistance, grants/ award letters
- Current pay stubs for the last 60 days
- Unemployment award notice/ benefits
- Letter from employer
- Household income
- Bank statements

We have separate Sliding Fee Scales for Medical, Dental and Pharmacy. Please be advised certain procedures (ex: IUD's, Vasectomies, Circumcisions, etc.), and X-Rays will be billed individually.

I certify that the information I have provided is true and correct to the best of my knowledge. I understand that I must report any change in my financial status so that my sliding fee can be adjusted accordingly and that failure to do so may result in the loss of sliding fee benefits. **I understand that I will be asked to re-apply annually.**

_____ _____

Patient or Guarantor Signature **Date**

For Office Use Only

Family Size: _____ Total Household Income: _____p/year, month, week (x.4.33)

Scale: _____ **Sliding Fee %: _____**

Approved By (Name and Signature): _____

Effective Date: _____Renewal Date: _____

Income Verified By:

Pay Stub, Check, Bank Statement, Letter of Employment, W-2 Form (choose one)

Klamath Health Partnership Inc.

Please mark which location you would like to receive your records:

☐ Klamath Open Door ☐ Campus Convenient Care ☐ Chiloquin Open Door ☐ School-based Health Center

Mail Records to: 2074 S. 6th Street, Klamath Falls, OR 97601
Fax Records to: 541-885-7386

Patient Name: _____ **DOB:** _____

I authorize: _____

Address_____

Phone Number_____ Fax Number_____

To disclose health information that includes the following: (please **initial** everything that applies)

Chart notes_____ Meds List_____ EKG/Treadmill_____ Immunizations_____ HIV/AIDS_____

Lab Reports_____ Radiology Reports_____ Substance Abuse _____ Mental Health_____

Please disclose the above selected records for: ☐ Last 6 Mo. ☐ Last 1 Yr ☐ Last 2 Yrs ☐ All ☐ Other_____

To: _____

Address_____

Phone Number_____ Fax Number **541-885-7386**

For the purpose of _____

I understand that the authorization to disclose my health information is voluntary. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services.
The only circumstance in which refusal to sign means you will not receive health care services, is if the health care services represent research related treatment and the authorization is necessary for you to participate.
I understand that I may review and receive a copy of the information described on this form and I am entitled to a copy of this authorization after I sign it.
I understand my medical record may be voluminous and agree to pay all reasonable charges associated with the copy and transfer of this record.
I understand that I may revoke this consent at any time provided that I do so in writing and except to the extent that action has already been taken.
I understand that the health information disclosed may be subject to re-disclosure by the recipient and no longer protected.
I understand that it may take up to 15 days to get the copy of my medical records.
I understand that I may contact the privacy officer if I have questions about disclosure of my health information at 541.851.8110.
ORS.192.563/42 CFR § 35.17 Health care provider and state health plan charges. A health care provider or state health plan that receives an authorization to disclose protected health information may charge no more than $15.00. Klamath Health Partnership charges $1.00 per page up to $15.00 except for Lab reports, Medication lists or Immunization history.

This consent will expire on: _____ or 180 days from the date of execution.
I give my permission for my medical information to be faxed to the above fax number. **(Initial)** _____

Patient Signature_____ **Date** _____

Patient Representative Signature_____ **Date** _____

School Based Health Center

Student Health History Questionnaire

Name: _____

Date of Birth: _____ **Age:** _____ **Today's Date:** _____

Welcome to the Klamath County School District School Based Health Center. We appreciate you choosing to see us for your care. We will ask you about your current health during your visit today, but please fill out this questionnaire. All of your answers are confidential. Thank you for allowing us to participate in your health care.

Please list any medications that you are taking:

_____

_____

_____

Please list any allergies to medications:

_____

_____

Past Medical History:

☐ ADD/ADHD	☐ Glasses or contacts	☐ Seizures
☐ Allergies (seasonal)	☐ Head injury/Concussion	☐ Sickle cell
☐ Anemia	☐ Headaches	☐ STDs
☐ Asthma	☐ Hearing problem	☐ Strep throat (recurrent)
☐ Broken Bones	☐ Heart murmur/Heart problems	☐ Thyroid disease
☐ Depression/Anxiety	☐ Immune deficiency	☐ Tuberculosis
☐ Diabetes	☐ Meningitis	☐ Urinary tract infections
☐ Eating disorder/Weight problems	☐ Pneumonia	☐ Varicella (chicken pox)
☐ Eczema/Skin problems	☐ Scoliosis	☐ Vision problems

☐ Other: _____

Surgical History:

☐ Adenoidectomy/Tonsillectomy ☐ Cosmetic surgery ☐ Hernia repair

☐ Appendectomy ☐ Fracture surgery ☐ Ear tubes

☐ Cleft lip/Cleft palate ☐ Heart surgery ☐Testicular surgery

Other: _____

Social History:

What school do you attend? _____

Who do you live with? _____

Do you feel safe at home? Yes/No Are there firearms in your home? Yes/No

Do you smoke? Yes/No Do you vape? Yes/No

Date of last dental visit? _____

Who is your primary medical provider? _____

Females only:

Age periods started: _____ Last menstrual period: _____ On birth control? Yes/No

If yes, type of birth control: _____

Family medical history: Please indicate if anyone in your ***immediate family*** (parents, siblings, grandparents) have the following:

Diabetes: _____ Seizures: _____

Cancer: _____ High blood pressure: _____

Kidney problems: _____ Heart disease: _____

Asthma/COPD: _____ Bleeding problems: _____

Mental illness: _____ Skin problems: _____

Stroke: _____ Anemia: _____

Thyroid disorder: _____ Migraine headaches: _____

Alcohol or drug abuse: _____

Greenway Patient Portal Agreement

Email Address: _____

Welcome to our new patient portal. You will be able to receive information such as appointments, lab results, and correspondence with your provider. You will need a valid email address to sign up for the patient portal.

Thank you for signing up for our Greenway Portal. Here is a brief summary of the guidelines surrounding the patient portal.

1. **Patient Portal messages are to be used for non-urgent matters only.**
   Please use phone contact and/or appropriate emergency services for urgent or emergent matters.

2. **Patient Portal messages will be answered within 2 business days.**
   If you have not heard back, please contact us by phone at 541-851-8110.

3. **Please use respectful language in Patient Portal messages.**
   Aggressive or abusive language may be grounds for deactivation of the Patient Portal account.

4. **Please be respectful of clinic resource.**

Frequent messaging to the clinical team (such as more than 2 messages in a day) may be grounds for deactivation of the Patient Portal account due to the teams' need to be able to serve all patients equally.

Flor Mounts, MD
Medical Director
Klamath Health Partnership

I have read and understand the guidelines for the Klamath Health Partnership's Online Patient Portal.

_____ Date: _____
Signature

_____
Printed Name