KNOX COUNTY COMMUNITY Health Center
KNOX PUBLIC HEALTH

Annual Consent For Care

Patient Name: _____ **Patient Date of Birth:** _____

ALL PATIENTS:
I give my consent for the Knox County Community Health Center (KCCHC) to provide treatment. _____ (Initial)

RELEASE/SHARING OF INFORMATION
I authorize the KCCHC to **release** and **obtain** verbal, written and electronic health information about the above-named client to and from health care providers involved in the medical and/or dental treatment and management of the client's medical or dental care and with specialists we may refer to.

I authorize release of all health information except: _____

I understand that these records are protected under federal and state laws and regulations and cannot be disclosed without my written consent unless otherwise provided by law.

We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment, or other healthcare operations. This is a voluntary agreement. You may opt- out at any time by notifying the office administrator.

I authorize the KCCHC to release any information from my medical/dental records to medical assistance, Medicaid, Medicare, other governmental payers, private insurance companies or plans or organizations acting on their behalf, as may be necessary to determine benefits and process claims and others involved in the collection of accounts.

I understand as condition of receiving care with KCCHC, KCCHC may use or disclose my personally identified health information for such treatment, payment and health care operation purposes. These uses and disclosures are more fully explained in the *Notice of Privacy Practices* that has been made available to me and I have reviewed.

I understand the privacy practices described in the *Notice of Privacy Practices* may change over time and that I have a right to obtain any revised *Privacy Notice* by contacting the Knox County Community Health Center to make a request. KCCHC is located at 11660 Upper Gilchrist Road, Mount Vernon, Ohio 43050.

I understand I have the right to revoke/withdraw this consent, in writing, at any time. My revocation will be effective except to the extent KCCHC has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

I authorize release of my medical information necessary to process the claim. I also authorize payment of benefits to the provider of service or supplier when the provider of service or supplier accepts assignment on the claim.

I have received an explanation of the risks and benefits for all services received and my questions have been answered. I also understand I have the right to refuse services at any time. If I refuse services, KCCHC will make efforts to ensure that I understand the implication and potential consequences of refusing or withdrawing consent for services

Who may we discuss and share your health records with during this Annual Consent period?
I give KCCHC authorization to share my health records with:

Name: _____ *Phone:* _____

Name: _____ *Phone:* _____

Signature of Patient (If patient is a minor parent or guardian):_____ **Date**_____

If Minor Relationship to Patient:_____ **Date**_____

Witness Signature: _____ **Date** _____

KNOX COUNTY COMMUNITY Health Center
KNOX PUBLIC HEALTH

Annual Patient Demographics - 1

Dear Patient: This center provides low cost health care regardless of ability to pay. We are the Medicaid provider of choice; accept Medicare and several insurance products. If you have these products or "self-pay" you may qualify for a discount called the Sliding Fee Scale. Nominal fees and payment arrangements are also available. To qualify for the "sliding fee scale" you must provide proof of household income and the household occupancy. (See Sliding Fee Scale Application for further information) **We are required to collect personal information as part of our FQHC grant agreement which is how we keep costs low.** Thank you for understanding the need for this information.

Patient Information: ***Today's Date:*** _____

Last Name: _____First Name: _____MI:_____

Any other name patient may have gone by in past: _____ Date of Birth: _____

Address: _____ City: _____ Zip Code: _____

County: _____ SS#_____-_____-_____ Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____

How do you prefer to be reminded of your appointment ☐ Text ☐ Call Email Address:_____

By providing email address you are acknowledging authorization to send correspondence by this medium.

Complete if Patient is a Minor:

For all minor patients (under 18 years of age), legal guardians will be asked to show documentation to prove that a legal relationship exists. This is for both the safety of the child and guardian and to ensure that the legally appointed parent or guardian is responsible for making medical decisions on behalf of the minor. **Applicable legal documents pertaining to custody, divorce, separation, adoption or name change of parent or child are required.**

Parent/Guardian Name:_____ Relationship to Patient: _____

Current Custody Status: ○ Parents ○ Sole Parental Custody ○ Joint Legal Custody ○ DSS Custody ○ Other:

Emergency Contact:

Last Name: _____ **First Name:_____**

Relationship to Patient:_____ **Emergency Contact Telephone Number:_____**

Responsible Party: ***Complete ONLY if Patient is 18 years old or younger, attending school, or has a legal guardian***

Last Name: _____ **First Name:_____**

Relationship to Patient:_____ **Responsible Party Telephone Number: _____**

Mailing Address (If different from patient):_____

Primary Insurance:	**Secondary Insurance:**
Insurance Company _____	Insurance Company _____
Participant' Name _____	Participant' Name _____
Participant's DOB _____	Participant's DOB _____
Participant's Relationship to Patient _____	Participant's Relationship to Patient _____
Participant's ID # or SS#_____	Participant's ID # or SS#_____

List number of people living in house (Please include self):

Adults (over 18 years of age)_____ Children (under 18 years of age)_____

Annual Household Income (Please check one): ○ Less Than $15,000 ○ $15,000 to $24,999 ○ $25,000-$34,999 ○ $35,000-$49,999 ○ $50,000 or more

I have reviewed the Sliding Fee Scale and I understand if my financial circumstances change I can apply for the Sliding Fee Scale at any time.

****I accept and have filled out the Sliding Fee Application:*** _____ (Initial) **(Complete Sliding Fee Application)**

*****Decline the Sliding Fee Scale at this time:*** _____ (Initial) **(Do NOT Complete the Sliding Fee Application)**

KNOX COUNTY COMMUNITY Health Center KNOX PUBLIC HEALTH

Annual Patient Demographics - 2

Living Arrangements: (Please check one)

☐ **Shelter** (Safe havens, temporary overnight housing, armories) ☐ **Transitional** (center, community home) ☐ **Other** (hotel, motel, day-to-day single room occupancy)	☐ **Doubling up** (living with other people for temporary period and move often) ☐ **Street** (sidewalk, car, park, doorway, public or abandoned building)	☐ **Permanent Residence** (own, rent, apartment/room/house)

***Student Status*:** ☐ Full time ☐ Part time ☐ Does not apply

Gender at Birth: ☐ Male ☐ Female ☐ Other
Current Gender Identity: ☐ Male ☐ Female ☐ Transgender male ☐ Transgender female ☐ Don't know ☐ Other:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Race: ☐ White ☐ African American ☐ Asian ☐ Other (Please specify): _____ ☐ Choose not to disclose

Ethnicity: ☐ Hispanic or Latino ☐ NOT Hispanic or Latino ☐ Unknown or choose not to disclose

Language: ☐ English ☐ Spanish ☐ Other (Please specify): _____ **Do you need an Interpreter:** ☐YES ☐ N0

Do you live within Mount Vernon city limits? ☐ YES ☐NO

Are you a veteran? ☐ YES ☐NO

How did you hear about Knox County Community Health Center? (Please check or circle)

- ☐ Returning or Existing Patient
- ☐ Mail—advertisement, postcard reminder
- ☐ Internet—web advertisement, website (Knoxhealth.com)
- ☐ Women's Infant and Children (WIC) Referral
- ☐ Knox Community Hospital Provider Referral
- ☐ Radio—T100, WNZR, WQIO
- ☐ Social Media – Facebook, Instagram, Twitter
- ☐ Behavioral or Mental Health Referral
- ☐ KAT bus advertisement
- ☐ Word of mouth—friend or family member
- ☐ Knox County Head Start

To the best of my knowledge, the above information is complete and correct. I understand that I am responsible to let the doctor or staff know of any changes in my, or minor child's health, demographic information.

I understand that I am responsible for notifying the Knox County Health Center if there is a change in the insurance coverage, address or telephone number. I acknowledge that co-payments or nominal fees are due and payable on the dates services are received.

_____ ***(Please Initial)***

Name of Patient/Responsible Party (Please Print):_____ Date _____

Signature of Patient/Responsible Party: _____ Date _____

KNOX COUNTY COMMUNITY Health Center
KNOX PUBLIC HEALTH

Patient Medical and Dental History

Today's Date: _____

Patient's Name: _____ **Date of Birth:** _____

Allergies: I do not have any allergies:_____ (Initial)
I have the following drug, environmental or food allergies (Write name and effect you had)

Drug/Environmental/Food Allergy	***What happens?***
Example: **Aspirin**	**I get a rash**

Check if you have or have had problems with any of the following:

***** IMPORTANT*****

- ☐ Heart transplant
- ☐ Congenital Heart Defect repaired with artificial material
- ☐ Surgical stents
- ☐ Artificial heart valves
- ☐ History of bacterial endocarditis
- ☐ Defective congenital heart repair
- ☐ Infection around previous heart defect repair
- ☐ Artificial joints within past 2 years

PLEASE CHECK THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST

Cardiac:
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heart Beat
- ☐ Stroke/TIA

Circulatory:
- ☐ Amputee
- ☐ Blood Clots
- ☐ Peripheral Artery Disease
- ☐ Peripheral Vascular Disease

Dental
- ☐ Bleeding Gums
- ☐ Grinding Teeth
- ☐ Loose Teeth/ Broken Filings
- ☐ Periodental Treatment
- ☐ Tooth Sensitivity

Endocrine
- ☐ Thyroid Disease
- ☐ Diabetes

Gastroenterology
- ☐ Bleeding Ulcers
- ☐ Diverticulitis
- ☐ Gallbladder
- ☐ GERD
- ☐ Hernia

Immune
- ☐ Lupus
- ☐ Rheumatoid Arthritis

Infectious Disease
- ☐ HIV
- ☐ MRSA
- ☐ VRE
- ☐ Hepatitis

Lungs
- ☐ Asthma
- ☐ COPD
- ☐ Obstructive Sleep Apnea
- ☐ Pulmonary Embolism
- ☐ Tuberculosis

Mental/ Behavorial Health
- ☐ ADD/ADHD
- ☐ Anxiety/ Depression
- ☐ Traumatic Event/ PTSD
- ☐ Other:_____

Musculoskeletal
- ☐ Arthritis
- ☐ Gout
- ☐ Open Wounds
- ☐ Osteoporosis

Renal
- ☐ Dialysis
- ☐ Kidney Disease

Cancer:
_____
_____

Addictions:
_____
_____

KNOX COUNTY COMMUNITY Health Center
KNOX PUBLIC HEALTH

Name:_____

Date of Birth:_____

Surgeries:

Example: Right knee replacement	***When*** 6 years ago

For Females Only:

Date of last period:	Date:	Concerns?
Have you ever been pregnant? • Currently pregnant • Currently breast feeding	Yes:☐ How many: _____ Yes:☐ No:☐ Yes:☐ No:☐	No:☐
Date of last PAP Smear	Date:_____ Where:_____	Any abnormal PAP results? (list)
Date of last MAMMOGRAM?	Date:_____ Where:_____	Any abnormal results? (list)

Name of Last Dentist Seen:

_____

City:_____ State:_____

Date of Last Dental Visit:_____

Did you have x-rays in the last year? ◯ Yes ◯ No

Name of Last Primary Care Provider (PCP) Seen:

_____

City: _____ State:_____

Date of last visit:_____

When was your last?

PSA9 Laboratory result (Male)		**Tetanus Vaccine**	
Pneumonia Vaccine		**Shingles Vaccine**	
Colonoscopy		**Cardiac Stress Test**	

Signature of Patient ***(If patient is minor parent/guardian):*** _____ ***Date:*** _____

If Minor Relationship to Patient: _____***Date:***_____

KNOX COUNTY COMMUNITY Health Center
KNOX PUBLIC HEALTH

Annual Patient Medication/Drug List

Today's Date _____

Patient Name: _____ **Date of Birth:**_____

ALL PATIENTS: This information will be held in **strict confidence** and will be used only for safe and appropriate care. Please provide the medication/drug name, the dosage you take, and the frequency of which you take the medication/drug. Please use the back of this page if you need more space.

Medications used during treatment may interact with both prescription and non-prescription drugs; including herbal supplements. These reactions may result in **SEVERE INTERACTIONS.** It is **extremely** important that you inform your provider of **any** drug you currently use or may have taken so that this may be considered in planning your treatment.

Conway's Pharmacy and **Wal-Mart of Mt. Vernon Pharmacy** are preferred by the Health Center. Most prescriptions are electronically transmitted for your convenience. Please list **Conway's**, **Wal-Mart** or another pharmacy you prefer.

Pharmacy Name: _____ ***Pharmacy Town:***_____

Medication/Drug	Dosage	How many times a day	What are you taking it for
EXAMPLE: Lisinopril	***10 mg***	***2 MORNING __ NOON ___ DINNER 2 BED***	***High blood pressure***

Medication/Drug	Dosage	How many times a day	What are you taking it for
EXAMPLE: Lisinopril	***10 mg***	***2 MORNING __ NOON ___ DINNER 2 BED***	***High blood pressure***

KNOX COUNTY COMMUNITY Health Center
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Medical / Dental

Patient No-Show and Appointment Cancellation Acknowledgment

To Our Valued Patients:

We strive to provide excellent care to our patients. As part of providing quality care to everyone, we must ensure our providers' time is spent caring for our patients. Therefore, we enforce a Patient No-Show and Cancellation Acknowledgment we expect all patients to acknowledge. If you are unable to attend an appointment, we request you cancel your appointment ahead of time. To cancel your appointment, please call 740-399-8008 and leave your name, date of birth and the appointment date and time you need to cancel.

Arriving to an appointment more than 15 minutes late or simply not calling or showing for a scheduled appointment are all considered a "no-show" for that appointment.

We understand situations may arise preventing you from arriving to your scheduled appointment. If you arrive after your scheduled appointment time, you are not guaranteed to be seen at that time. You could be asked to reschedule your appointment to prevent delays or inconveniences for other patients.

After three no-show appointments occurring in a six (6) month period, you can still use the Health Center but only on a walk-in basis for the next six (6) months. The enforcement of this acknowledgment is at the discretion of the counselor/provider.

If you are a parent or guardian of a minor, you are responsible for their appointments and the same process will be used for a minor's no-show appointment.

I have read and understand the Patient No-Show and Appointment Cancellation Policy of the Knox County Community Health Center and I agree to the terms. I also understand such terms may be amended periodically by the practice.

Print Patient Name: _____ **DOB:** _____
Patient Signature: _____ **Date:** _____
Parent/Guardian Signature (if under 18): _____ **Date:** _____

KNOX COUNTY COMMUNITY Health Center KNOX PUBLIC HEALTH

Informed Consent for Telehealth Services: Medical/Dental

I, _____, consent to engaging in telehealth with the Knox County Community Health Center as a part of the medical or dental health services. I understand that telehealth services may include health evaluation, assessment, consultation and/or treatment planning. It has been explained how telehealth will be used and that it is not the same as a direct patient/healthcare provider visit. Telehealth will occur primarily through telephonic, interactive audio and/or video communications.

By signing this consent, I am verifying that I understand the following:

1. I have the right to withhold or remove consent for telehealth services at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.
2. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is confidential, just as it would be if I were in the clinic. I understand that the visit is transmitted over dedicated lines and cannot be accessed by any unauthorized individuals.
3. I give my consent to be interviewed by the consulting healthcare provider. I also understand that other individuals may be present to operate the video equipment and that they will take reasonable steps to maintain confidentiality of the information obtained.
4. I understand that a limited examination may take place during the telephonic or videoconference and that I have the right to ask my healthcare provider to discontinue the conference at any time. I understand that some parts of the exam may be conducted by individuals at my location at the direction of the consulting healthcare provider.
5. I agree that certain situations including emergencies and crises are inappropriate for telehealth services. If I am in crisis or in an emergency, I should immediately call 911 or go to the nearest hospital or crisis facility.
6. I understand that there may be technological issues such as interruptions or difficulties which may occur. Due to this, my health care provider or I can discontinue the telehealth consult/visit if it is felt that the audio\video teleconferencing connections are not adequate for the situation.
7. I hereby release Knox County Community Health Center, its personnel, and any other person participating in my care from any and all liability which may arise from the taking and authorized use of such digital images or radiographs.
8. I understand that billing will occur from the healthcare provider and facility based on the telehealth services provided.
9. I have read this document and understand the risk and benefits of the telemedicine services and have had my questions regarding the services explained and I hereby consent to participate in a telehealth visit under the conditions described in this document.

I have read this document and understand the risk and benefits of telehealth services and have had my questions regarding the services explained. I hereby consent to participate in a telehealth visit under the conditions described in this document.

_____ [Initial] **Verbal Consent:** In lieu of the required written consent or beneficiary signatures, verbal permission was requested and received prior to initiating the telehealth visit having covered all the items in the Informed Consent.

Print Patient Name: _____ **DOB:** _____
Patient Signature: _____ **Date:** _____
Parent/Guardian Signature (if under 18): _____ **Date:** _____

KNOX COUNTY COMMUNITY Health Center
KNOX PUBLIC HEALTH

Sliding Fee Application

Initial Application_____ Year____ | Renewal_____ Year____

Today's Date:_____

Applicant's Name: _____ Date of Birth: _____
Address: _____
City: _____ State:_____ Zip:_____
Phone #1_____ Phone #2_____

It is the policy of the Knox County Community Health Center (KCCHC) to provide essential medical, mental health, behavioral health, and dental services regardless of the patient's ability to pay. If qualified, a discount may be applied to copayment, co-insurance, and/or deductible balances that are greater than the nominal fee. To qualify for the "sliding fee scale" you must provide proof of household income and the household occupancy. The current nominal fee is $30 for medical services, $10 for mental and behavioral health services, and $40 for dental services.

Please Note: Lab fees are deeply discounted and the actual cost of the lab presented to KCCHC is charged to the patient with no mark-up or additional service fees application.

		Household Income (complete only ONE column per member)*		
Household Members First and last name	***Date of Birth***	***Annual***	***Monthly***	***Bi-Weekly***
Self				
TOTAL INCOME*		***$***	***$***	***$***
# of Dependent Children Under Age 18				

**Income includes all earned income/wages and unearned income including wages, salaries, tips, long term disability, self-employment, unemployment, social security, pensions/retirement, and worker's compensation.*

Total number of members living in your household (self + spouse + children + other qualified members above): ☐

SLIDING FEE DISCOUNT AGREEMENT: I understand and agree that some services rendered are based on my ability to pay. If payment for other services is determined by and based on a sliding fee scale, I understand I am responsible for my share of the cost of services rendered at time of service and that failure to provide "proof of income" will result in me being charged 100% of the cost of services received and/or provided.

I agree, whether as a patient, agent, guardian, relative, or representative, that in consideration of the services rendered, I hereby individually guarantee and obligate myself to pay the account of the KCCHC in full. I further understand that failure to comply with my responsibilities for payment of services rendered may result in suspension of appointments.

I certify that the family size and income information shown above are correct. Copies of tax returns, pay stubs, and or/other information verifying income are required prior to approval of a discount. If defined documentation is unavailable, I will complete and sign the IRS 4506-T form to support this income statement

Signature of Patient/Guardian (If patient is minor): _____ **Date** _____

If Guardian, Relationship to Patient: _____

Created: 4/17/2018
Revised: 1/1/2020