



# KLAMATH HEALTH PARTNERSHIP

*"Our mission is to provide accessible, culturally sensitive, affordable, quality-driven, responsive, patient-centered health services to our community, with an emphasis on those who need us most."*

**MEDICAL | DENTAL | BEHAVIORAL HEALTH | PHARMACY**

## WE CAN PROVIDE:

- Transportation to and from appointments
- Assistance signing up for insurance at little or no cost to you
- Med-Sync medication management
- Sliding Fee Discount for services

## CONTACT PATIENT RESOURCES ABOUT:

- **DRUG ASSISTANCE PROGRAMS**  
Patient Resources assists patients in filling out and submitting the required applications to the pharmaceutical companies who offer assistance programs.
- **OREGON HEALTH PLAN**  
Patient Resources can help patients fill out and submit applications for the Oregon Health Plan.
- **COMMUNITY RESOURCES**  
Patient Resources can help patients obtain vital community resources.



**CALL 541-880-2078 TO REACH OUR PATIENT RESOURCES TEAM**

## SERVING YOU AT THESE CONVENIENT LOCATIONS:

<p><b>KLAMATH OPEN DOOR FAMILY PRACTICE</b></p> <p>2074 S. 6th Street Klamath Falls, OR 97601</p> <p><b>Phone:</b> 541-851-8110 <b>Fax:</b> 541-851-8114</p> <p><b>Hours:</b> Mon-Fri: 7am – 7pm Sat.: 8am – noon Sun.: <b>CLOSED</b></p>	<p><b>CHILOQUIN OPEN DOOR FAMILY PRACTICE</b></p> <p>103 S. Wasco Avenue Chiloquin, OR 97624</p> <p><b>Phone:</b> 541-783-2292 <b>Fax:</b> 541-783-3160</p> <p><b>Hours:</b> Mon-Wed, Fri: 8am – 6pm Thurs, Sat, &amp; Sun: <b>CLOSED</b></p>	<p><b>PINE STREET OPEN DOOR</b></p> <p>403 Pine Street Klamath Falls, OR 97601</p> <p><b>Phone:</b> 541-851-8110 <b>Fax:</b> 541-851-8114</p> <p><b>Hours:</b> Mon-Fri: 8am – 6pm Sat &amp; Sun: <b>CLOSED</b></p>	<p><b>KLAMATH OPEN DOOR PHARMACY</b></p> <p>2074 S. 6th Street Klamath Falls, OR 97601</p> <p><b>Phone:</b> 541-880-2094 <b>Fax:</b> 541-851-0190</p> <p><b>Hours:</b> Mon-Fri: 8:30am – 6pm Sat. &amp; Sun: <b>CLOSED</b></p>
<p><b>KOD @ KBBH</b></p> <p>2210 N. Eldorado Avenue Klamath Falls, OR 97601</p> <p><b>Phone:</b> 541-851-8110 <b>Fax:</b> 541-851-8114</p> <p><b>Hours:</b> Thursday: 8am – 5pm</p> <p>Open to established patients of KBBH</p>	<p><b>KLAMATH COUNTY SCHOOL-BASED HEALTH CENTER</b></p> <p>3013 Summers Lane Klamath Falls, OR 97603</p> <p><b>Phone:</b> 541-887-8189 <b>Fax:</b> 541-884-1126</p> <p><b>Hours:</b> Mon, Wed: 8am – 5pm Fri: 8am – noon</p>	<p><b>CAMPUS CONVENIENT CARE</b></p> <p>2684 Campus Drive Klamath Falls, OR 97603</p> <p><b>Phone:</b> 541-851-8110 <b>Fax:</b> 541-851-8114</p> <p><b>Hours:</b> Mon-Fri: 8am – 5pm Sat. &amp; Sun: <b>CLOSED</b></p>	<p><b>KLAMATH OPEN DOOR DENTAL</b></p> <p>2074 S. 6th Street Klamath Falls, OR 97601</p> <p><b>Phone:</b> 541-880-2090 <b>Fax:</b> 541-880-2092</p> <p><b>Hours:</b> Mon-Fri: 8am – 6pm Sat. &amp; Sun: <b>CLOSED</b></p>

After Hours Nurse Advice Line available for all locations by calling 541-851-8110



# KLAMATH HEALTH PARTNERSHIP, INC

## NOTICE OF PRIVACY PRACTICES

Effective 01/2023

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION 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, Privacy Officer, at (541) 851-8110 or by mail at 2074 South 6<sup>th</sup> Street, Klamath Falls, OR 97601.*

**PURPOSE** – Klamath Health Partnership (KHP) is committed to protecting your protected health information, and we encourage you to contact our Privacy Officer should any issue or question arise. This Notice of Privacy Practice (“Notice”) describes the processes our staff follow to protect your protected health information (PHI). We are required by law to give you this Notice. This Notice explains how and when we may use or disclose your PHI but may not include every possible situation. This Notice describes your rights and our responsibilities regarding the use and disclosure of PHI.

**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 KHP. Your health information may include information created and received by this office, may be 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.

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU** – We may use and disclose health information without your consent:

**For Treatment.** We may use your health information to provide you with treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in your care. Staff in our office may share information about you with people who do not work in our office to coordinate your care, such as phoning in prescriptions to your pharmacy or ordering lab work or imaging studies. Family members and other healthcare providers may be part of your medical care outside this office and may require information about you that we have.

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.

**For Payment.** We may use and disclose health information about you to bill for the treatment and services you receive from us and to collect payment from you, a health plan, or another third party. We may tell your health plan about a treatment you are going to receive to get prior approval, or to determine whether your plan will pay for the treatment.

**For Health Care Operations.** We may use and disclose PHI to run or improve our office, programs, or services, 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 to help us decide which additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

**Appointment Reminders.** We may use and disclose PHI to contact you to remind you about appointments for treatment or health care.

**Treatment Alternative/Health-Related Benefits and Services.** We may use and disclose PHI to contact you about or recommend possible treatment options or alternatives or health-related benefits and services that may be of interest to you.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. We will only disclose PHI to someone who may be able to help prevent the threat.

**Required By Law.** We will disclose health information about you when required to do so by federal, state, or local law. We may disclose PHI in response to a court order.

**Research.** We may use and disclose PHI for research projects that are subject to a special approval process. We may use and disclose a limited data set that does not contain specific identifiable information about you for research. We will only disclose this limited data set if we enter into a data use agreement with the researcher. 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 your PHI to organizations that handle organ procurement 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 your PHI. We may also release information about foreign military personnel to the appropriate foreign military authority.

**Minors.** We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

**Workers' Compensation.** We may release your PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

**Abuse, Neglect, or Domestic Violence.** We may disclose PHI to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make such disclosures.

**Inmates.** We may disclose your PHI if you are an inmate of a correctional institution or under the custody of a law enforcement official to such agencies if the disclosure is necessary for the institution to provide you with health care, protect your health and safety or the health and safety of others, or the safety and security of the correctional institution.

**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; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

**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 your PHI 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 your PHI to a coroner or medical examiner as necessary 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. 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, use or disclose to your family member or friend if in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care.

**Data Breach Notification.** We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information. You have the right to know of a breach of any of your unsecured PHI.

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 the 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 under your permission.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES – The following uses and disclosures of your PHI will only be made with your specific, written authorization:

- Disclosure of specially-protected information such as HIV, substance abuse, mental health, and genetic testing information;
- Uses and disclosures of PHI for marketing purposes; and,
- Disclosures that constitute the sale of PHI;

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU – You have the following rights regarding your health information:

**Right to Inspect and Copy.** You have the right to inspect and obtain a copy of your PHI, such as medical and billing records, to make decisions about your care. You must submit a written request to inspect and/or obtain a copy of your PHI records. We have up to 15 days to make your PHI available and may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request 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 by a licensed health care professional not directly involved in your care.

**Right to Amend.** If you believe the health information we have about you is incorrect or incomplete, you may ask us to amend the health information we keep. You have the right to request an amendment as long as the information is kept by us. A request for amendment must be made in writing to our Privacy Officer via our *Medical Record Amendment/Correction Form*. In some cases, we may deny your request for an amendment, such as if your request is not in writing or does not include a reason to support the request.

**Right to an Accounting of Disclosures.** You have the right to request an “accounting of disclosures of your Protected Health Information.” 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. The first list you request within a 12-month period will be free. We may charge you for the costs of providing additional lists. We will notify you of the cost involved, and you may choose to withdraw or modify your request at the 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. A request for a restriction must be made in writing to our Privacy Officer. ***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 with emergency treatment or we are required by law to use or disclose the information.

**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. This request must be made in writing. No reason is necessary. We will accommodate all reasonable requests.

**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. Contact KHP to request a paper copy of this Notice.

**Right to a File a Complaint.** You have the right to file a complaint if you feel your privacy rights have been violated. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint. You may file a complaint by contacting our Privacy Officer or the U.S. Department of Health and Human Services through the contact information provided below:

Klamath Health Partnership  
Privacy Officer  
2074 S. 6<sup>th</sup> Street, Klamath Falls, OR 97601  
541-851-8110

U.S. Department of Health and Human Services  
Office for Civil Rights  
200 Independence Ave. S.W., Washington D.C. 20201  
1-877-696-6775  
[www.hhs.gov/ocr/privacy/hipaa/complaints](http://www.hhs.gov/ocr/privacy/hipaa/complaints)

**CHANGES TO THIS NOTICE** – We reserve the right to change this Notice and to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post the current Notice (or summary of the current Notice) in the office with its effective date on the document. You are entitled to a copy of the Notice currently in effect.



# KLAMATH HEALTH PARTNERSHIP, INC NOTICE ABOUT NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

## Discrimination is Against the Law.

Klamath Health Partnership, Inc. complies with applicable federal and state civil rights laws and does not exclude or treat people differently because of race, ethnicity, color, national origin, age, disability, gender, 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)
- 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 at 541-851-8110.

If you believe that Klamath Health Partnership or an employee has failed to provide these services or discriminated in another way on the basis of race, ethnicity, color, national origin, age, disability, gender, or sex, you can file a grievance with our Compliance Officer or through the Office for Civil Rights under the U.S. Department of Health and Human Services.

Klamath Health Partnership  
Compliance Officer  
2074 S. 6<sup>th</sup> Street  
Klamath Falls, OR 97601  
541-930-7835  
[feedback@kodfp.org](mailto:feedback@kodfp.org)

Office for Civil Rights  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
800-368-1019  
800-537-7697 (TDD)  
<http://www.hhs.gov/ocr/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 (Ukrainian) 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。

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

**ລາວ (Lao) ໂບດລາວ:** ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີຮ່ວມໃຫ້ທ່ານ. ໂທ 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 Majōl, kwomaroñ bōk jerbāl in jipañ ilo kajin ñe aṃ ejjelōk wōṇāān. Kaalōk 1-541-851-8110

**ភាសាខ្មែរ (Cambodian) ប្រយ័ត្ន:** បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល គឺអាចមានសំរាប់បម្រើអ្នក។ ចូរ ទូរស័ព្ទ 1-541-851-8110

**မြန်မာ (Burmese) သတိပြုရန် -** အကယ်၍ သင့်ညွှန် ဖုန်းစကားကို ဝေမျှပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အကြံကို စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-541-851-8110 သို့မူ့ ဝေငှအိပါ။





# KLAMATH HEALTH PARTNERSHIP, INC ACKNOWLEDGMENT AND CONSENT

## CONSENT TO PRIVACY PRACTICES AND DISCLOSURES

**Klamath Health Partnership** has a Notice of Privacy Practices that gives information about how the practice may use and release protected health information about patients. Protected 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 my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

By signing this form, I agree and understand that Klamath Health Partnership may use and disclose my health information to:

- Provide treatment;
- Collect payment;
- Conduct healthcare operations, such as supporting my provider in delivering quality, cost-effective services; and
- As otherwise permitted under HIPAA regulations and outlined in the Notice of Privacy Practices.

By signing this form, I agree and understand that:

- I have the right to receive a copy of the Notice of Privacy Practices and may request another copy any time.
- I was given a copy of the current Notice of Privacy Practices at time of form completion.
- That the Notice may be revised, and I have the right to a copy of any revised Notice of Privacy Practices.
- That a copy or summary of the most current version of the Notice of Privacy Practices is available on the practice's website at: <http://www.klamathopendoor.org>

## CONSENT TO TREATMENT

By signing this form, I agree to receive medical and/or dental care from Klamath Health Partnership. I understand that:

- This consent to treatment will be effective as long as I am seen at any Klamath Health Partnership location.
- I may cancel this consent to treatment in writing at any time.

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***By signing below, I agree that this document was given to me in a language I understand or read to me in its entirety and agree to and understand the statements made above.***

Signature (Patient / Legal Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

Print Name (Patient / Legal Guardian): \_\_\_\_\_ Relationship: \_\_\_\_\_



# KLAMATH HEALTH PARTNERSHIP, INC

## PATIENT AGREEMENTS

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

*Please initial each statement.*

**Copayments and deductibles are due at the time of service.**

\_\_\_\_\_ I understand that copayments are due at the time of service. I understand that elective procedures not covered by insurance must be paid in full before that procedure can be scheduled.

**Medications.**

\_\_\_\_\_ I will provide a medication list, including vitamins and herbal supplements, to my provider at my first appointment.

\_\_\_\_\_ I understand that some medications, including opiate pain medications (Oxycodone, Methadone, Norco, etc.) and benzodiazepines (Ativan, Valium, Xanax, etc.) **will not be filled at my first patient visit.**

**Prescription Refills.**

\_\_\_\_\_ I understand KHP has 72 business hours to process refill requests. I will contact my pharmacy for prescription refills unless instructed otherwise by your provider.

**PBM Consent.**

\_\_\_\_\_ I consent to Klamath Health Partnership disclosing my health information to my Prescription Benefit Manager as necessary to coordinate and provide my pharmacy or prescription benefits.

**New Patients.**

\_\_\_\_\_ I understand that new patients who fail to attend **2** New Patient appointments without cancelling 24 hours in advance may prevent future scheduling at any Klamath Health Partnership location.

**Check-in Time.**

\_\_\_\_\_ I will arrive 15 minutes prior to my scheduled appointment time.

**Late Arrival.**

\_\_\_\_\_ I understand that my appointments may have to be rescheduled if I arrive more than 10 minutes late.

**Cancelled Appointments.**

\_\_\_\_\_ I will cancel any appointments at least 24 hours in advance.

**Failed Appointments (No-shows).**

\_\_\_\_\_ I understand that failing **3 or more** appointments may result in dismissal from the practice.

**Insurance Billing.**

\_\_\_\_\_ I will provide the practice with complete and accurate insurance information at every visit. I understand that I may be billed for visits and services if my insurance information is inaccurate.

**Sliding Fee Discount Program.**

\_\_\_\_\_ I understand that all patients at Klamath Health Partnership may apply for the Sliding Fee Discount Program. I understand this program is based on annual income and must be updated annually.

**Labs.**

\_\_\_\_\_ Many lab specimens collected at Klamath Health Partnership are sent to Interpath Laboratory or Sky Lakes Laboratory to run the tests. Interpath and Sky Lakes bill separately for laboratory services. You can contact Interpath or Sky Lakes with questions about your lab bill.



# KLAMATH HEALTH PARTNERSHIP, INC

## PATIENT REGISTRATION & INFORMATION

### PATIENT INFORMATION

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Full Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_ Birth Sex:  Female  Male

Home Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Billing Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Preferred Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Primary Pharmacy: \_\_\_\_\_

Primary Language:  English  Spanish  Other: \_\_\_\_\_ Do you need an interpreter?  Yes  No

Race:  Asian Indian  Alaska Native  Black/African American  Chinese  Filipino  
 Guamanian / Chamorro  Japanese  Korean  Native American  Native Hawaiian  
 Other Asian  Pacific Islander  Samoan  Vietnamese  White  Other: \_\_\_\_\_

Ethnicity:  Not Hispanic  Cuban  Puerto Rican  Mexican or Chicano/a  Other Hispanic or Latino/a

### EMERGENCY CONTACT

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Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### GUARANTOR / RESPONSIBLE PARTY

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Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_  Patient is a Minor  Patient is Policy Holder  Patient is Person Responsible

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### PARENT / LEGAL GUARDIAN / REPRESENTATIVE INFORMATION

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Please list any biological or legal parent/guardian or legal representative (*proof required if legal guardian, representative, or medical power of attorney, etc.*). **Required for minor patients.**

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Mobile  Home  Other: \_\_\_\_\_  Mobile  Home  Other: \_\_\_\_\_

**COMMUNICATION PREFERENCES**

*Klamath Health Partnership may leave a voicemail for the following reasons: (check all that apply)*

- Appointment Reminders     Medical Information     Billing Information

**Klamath Health Partnership may send telehealth appointment details via email:**  Yes     No

**Use:**  Preferred Number **Only**     Any Personal Number (not including emergency contact)

- Parent/Guardian No.     Other Phone Number: \_\_\_\_\_

**PATIENT DEMOGRAPHICS**

*We are a Federally Qualified Health Center (FQHC) and collect the following information to improve patient services and provide the lowest cost care possible. All information is kept strictly confidential.*

**Gender Identity:**  Male  Female  Trans/Male to Female  Trans/Female to Male  Decline

**Sexual Orientation:**  Straight  Bisexual  Lesbian/Gay  Unsure  Decline

**Preferred Pronouns:**  He/Him  She/Her  They/Them  Decline  Other: \_\_\_\_\_

***Household Information:***

**How many people live in your household?** \_\_\_\_\_

**What is your total estimated household income per year?** \_\_\_\_\_ **per month?** \_\_\_\_\_

***Housing Status:***

**Have you or the patient experienced homelessness at any time in the past 12 months?**  Yes  No

***Employment Status:***

Full Time  Part Time  Self-Employed  Retired  Seasonal/Temporary  Unemployed

Student, if under 18, which school district/school: \_\_\_\_\_  Other: \_\_\_\_\_

**Are you veteran of the U.S. Military?**  Yes  No

***Migrant/ Seasonal Worker:***

**In the past 24 months, have you or another member of your household:**  Yes  No

- Been hired to do farm or agricultural work?
- Earned over half of your family income from farm work?

**In the past 24 months, have you or another member of your household:**  Yes  No

- Moved from this area to another country or state for farm or agricultural work?
- Lived in this area and only worked during harvest season?

**Is the patient a dependent of an agricultural or farm worker?**  Yes  No

**SIGNATURE REQUIRED** (*Communication and representative information may be updated at any time.*)

Signature (Patient / Legal Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

Print Name (Patient / Legal Guardian): \_\_\_\_\_ Relationship: \_\_\_\_\_



**KLAMATH HEALTH PARTNERSHIP, INC**  
**ASSIGNMENT OF BENEFITS**  
**CONSENT TO BILL INSURANCE**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Relationship to Policy Holder:  Self  Spouse  Child  Other: \_\_\_\_\_

Policy Holder SSN: \_\_\_\_\_ Policy Holder Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Address/City/State/Zip: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

I hereby consent for **Klamath Health Partnership, Inc.** to bill and collect for professional, dental, or medical expense benefits allowable and otherwise payable under this current insurance policy as payment towards the total charges for the professional and/or dental services rendered. A photocopy of the Assignment shall be considered as effective and valid as the original.

Payments made by insurance will not exceed my charges for services and I agree to pay any remaining balance billed, as patient and/or guarantor, not covered by insurance payment or contractual adjustment.

I authorize the release of any information pertinent to my care to any insurance company, adjuster, or attorney involved in my care. I authorize Klamath Health Partnership to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

\_\_\_\_\_  
**Signature of Policyholder**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Claimant, if other than Policy Holder**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
**Date**



**KLAMATH HEALTH PARTNERSHIP, INC**  
**INCOME VERIFICATION FORM**  
**SLIDING FEE DISCOUNT PROGRAM APPLICATION**

*This form may be used to apply for the sliding fee discount program for medical, dental, behavioral health, and pharmacy services.*

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ SSN: \_\_\_\_\_

*If guarantor or responsible party is different than patient, please provide name and information below:*

Guarantor Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

***Please list the members of your household:***

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

***Please list the household income received from any of the following sources:***

	Amount	How Often
Employment	\$ _____	_____
Unemployment	\$ _____	_____
Workers Compensation	\$ _____	_____
SSD / SSI	\$ _____	_____
Child Support	\$ _____	_____
Food Stamps	\$ _____	_____
Social Security Retirement Benefits	\$ _____	_____
Retirement / Pension Income	\$ _____	_____
Students Loans or Financial Aid	\$ _____	_____
Temporary Assistance for Needy Families (TANF)	\$ _____	_____
Other: _____	\$ _____	_____

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.

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**We require proof of income for the last 60 days. Documents that can be used 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

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.**

I understand there are **separate Sliding Fee Scales for Medical, Dental, and Pharmacy**. I understand that **certain procedures** (IUDs, vasectomies, circumcisions, etc.) and x-rays **are billed individually.**

\_\_\_\_\_  
**Patient or Guarantor Signature**

\_\_\_\_\_  
**Date**

**FOR OFFICE USE ONLY**

**Family Size:** \_\_\_\_\_ **Total Household Income:** \_\_\_\_\_ p/year, month, week (x.4.33)

**Scale:** \_\_\_\_\_ **% Poverty:** \_\_\_\_\_

**Approved By:** \_\_\_\_\_  
Name and Signature

**Effective Date:** \_\_\_\_\_ **Renewal Date:** \_\_\_\_\_

**Income Verified By:**  Pay Stub  Check  Bank Statement  Employment Letter  W-2 Form



# KLAMATH HEALTH PARTNERSHIP, INC

## AUTHORIZATION TO RELEASE/DISCLOSE INFORMATION

## AUTORAZCIÓN PARA DIVULGAR/REVELAR INFORMACIÓN

Campus  
Convenient Care

Chiloquin  
Open Door

Klamath  
Open Door

KOD @ KBBH

Pine Street  
Open Door

Klamath County  
School-based  
Health Center

**Many of our patients allow family member such as their spouse, parents, or others to call and request medical or billing information. We are not authorized to give this information to anyone without the patients consent. If you wish to have your medical or billing information released to a family member or another individual, please indicate their name and relationship:**

Muchos de nuestros pacientes permiten que miembros de la familia, como su pareja, padres, u otras personas llamen y soliciten información médica o de sobre su facturación. Nosotros no estamos autorizados a proporcionar esta información a nadie sin el consentimiento del paciente. Si usted desea que su información médica o su información sobre su cuenta medica sea compartida con otra persona, indique el nombre y el tipo de relación a continuación:

\_\_\_\_\_  
**Patient Full Name/Nombre Completo del Paciente**

\_\_\_\_\_  
**Date of Birth/Fecha de Nacimiento**

**I authorize the release of my health information from/ Yo autorizo la divulgación de mi información de salud de:**  
(Who has the information you want released? ¿Quién tiene la información que Ud. quiere sea revelada/obtenida?)

**Name/ Nombre:** \_\_\_\_\_

**Address/ Dirección:** \_\_\_\_\_

**Phone Number/ Numero de Tel.:** \_\_\_\_\_ **Fax Number/ Numero de Fax:** \_\_\_\_\_

**I authorize the above named entity to disclose health information that includes the following/ Yo autorizo que la entidad nombrada divulge información de salud que incluya lo siguiente: (Initial all that apply/ Iniciales en yodo lo que corresponda)**

**Progress Notes/ Notas de Progreso** \_\_\_\_\_ **Med List/Lista de Medicamentos** \_\_\_\_\_ **HIV/AIDS/VIH/SIDA** \_\_\_\_\_

**EKG/Electrocardiograma** \_\_\_\_\_ **Immunizations/Inmunizaciones** \_\_\_\_\_ **Radiology Reports/ Reportes de Radiología** \_\_\_\_\_

**Labs/Laboratorios** \_\_\_\_\_ **Substance Use/ Uso de Sustancias** \_\_\_\_\_ **Mental Health/Salud Mental** \_\_\_\_\_

**Billing/Facturación** \_\_\_\_\_

**Disclose the selected records for/ Revelar los registros seleccionados para**  Last 6 Mo.  Last 1Yr.  Last 2Yrs.  All/Todo  
**Other/Otro:** \_\_\_\_\_

**For the purpose of/Para el propósito de:** \_\_\_\_\_

**I authorize the release of my health information to/ Yo autorizo la divulgación de mi información de:**  
(Where do you want the information sent? ¿Dónde desea que se enví la información?)

**Name/ Nombre:** \_\_\_\_\_

**Address/ Dirección:** \_\_\_\_\_

**Phone Number/ Numero de Tel.:** \_\_\_\_\_ **Fax Number/ Numero de Fax:** \_\_\_\_\_

**Mail Records to:** 2074 S. 6th Street, Klamath Falls, OR 97601

**Fax Records to:** 541-885-7386



**ENGLISH**

- 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 are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.
- 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.
- Under 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.

**ESPAÑOL**

- Entiendo que la autorización para divulgar mi información de salud es voluntaria. El negarme a firmar la autorización no afectara negativamente mi capacidad de recibir servicios de atención médica o el reembolso de los servicios.
- La única circunstancia en las que el negarme a firmar significa que no voy a recibir los servicios de salud es si los servicios de cuidado de la salud son para el único fin de proporcionar información de salud a otra persona y la autorización sea necesaria para realizar dicha divulgación.
- Entiendo que puedo ver y recibir una copia de la información descrita en este formulario y tengo derecho a una copia de esta autorización después de firmarla.
- Entiendo que mi registro medico puede ser voluminoso y estoy de acuerdo en pagar todos los cargos razonables asociados con la copia y transferencia de este registro.
- Entiendo que puedo revocar este consentimiento en cualquier momento, siempre que lo haga por escrito y excepto en la medida en que ya se haya tomado medidas
- Entiendo que la información de salud divulgada puede estar sujeta a una nueva divulgación por parte del destinatario y no estar protegida.
- Entiendo que puede tomar hasta 15 días para obtener la copia de mi registro médico.
- Entiendo que puedo contactar al oficial de privacidad si tengo preguntas sobre la divulgación de mi información de salud al 541-851-8110. La ley de Oregón ORS.192.563/42 CFR § 35.17 Un Proveedor de atención médica o un plan de salud estatal que reciba una autorización para divulgar información médica protegida no puede cobrar más de \$15.00. Klamath Health Partnership cobra \$1.00 por página hasta \$15.00 excepto Laboratorios, Lista de Medicamentos, o Historial de Vacunas.

**This consent will expire on/ Este consentimiento se vencera el:** \_\_\_\_\_ **or 180 days from the date of execution/ o 180 días del la fecha de ejecucion.**

**I give my permission for my medical information to be faxed to the above fax number/ Soy mi permiso para que mi información médica sea enviada por fax al número de fax. (Initial/Inciales)** \_\_\_\_\_

**Patient Signature/Firma del Paciente:** \_\_\_\_\_ **Date/Fecha:** \_\_\_\_\_

**Patient Representative Signature/Firma del Representante del Paciente:** \_\_\_\_\_

**Date/Fecha:** \_\_\_\_\_

**Mail Records to:** 2074 S. 6th Street, Klamath Falls, OR 97601

**Fax Records to:** 541-885-7386



# KLAMATH HEALTH PARTNERSHIP, INC

## HEALTH HISTORY QUESTIONNAIRE

### Adult

Please fill out this form to the best of your knowledge. We will ask about your current health during your visits, but this form helps us understand your health and how to best care for you. All answers are **confidential**.

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Today's Date: \_\_\_\_\_

#### PATIENT MEDICAL HISTORY (Check all health issues that you have)

<input type="checkbox"/> Anemia	<input type="checkbox"/> Depression	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Liver disease
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Lung disease
<input type="checkbox"/> Arrhythmia / A-Fib	<input type="checkbox"/> Eczema	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Migraines
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Hernia	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Blood clots	<input type="checkbox"/> GERD/Acid reflux	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> STD/STI
<input type="checkbox"/> Bowel polyps	<input type="checkbox"/> Gall stones	<input type="checkbox"/> High cholesterol/Abnormal lipids	<input type="checkbox"/> Stroke
<input type="checkbox"/> Breast lump	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> IBS (Irritable bowel syn.)	<input type="checkbox"/> Thyroid problem
<input type="checkbox"/> Concussion	<input type="checkbox"/> Gout	<input type="checkbox"/> IBD (Inflammatory bowel)	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Constipation	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Urinary tract infections
<input type="checkbox"/> COPD	<input type="checkbox"/> Headaches	<input type="checkbox"/> Kidney/bladder issues	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Cancer (Type: _____)	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

#### SURGERIES / HOSPITALIZATION

Date	Type / Reason

#### FAMILY HEALTH HISTORY (grandparent, parents, siblings)

Problem	Relation	Age	Type
Cancer			
Depression			
Diabetes			
Heart attack			
High blood pressure			
High cholesterol			
Stroke			
Other			

#### IMMUNIZATIONS

(Provide date of last vaccination)	
Tetanus / Pertussis:	_____
Pneumonia:	_____
Influenza (flu):	_____
COVID-19	_____
(provide all dates	_____
and types)	_____
If born after 1957, have you had a second measles / mumps / rubella (MMR) vaccine?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	

#### REPRODUCTIVE HEALTH

Number of Pregnancies: _____ Miscarriages: _____ Abortions: _____		
Year of Birth	Gender	Complications (if any)
Last menstrual period: _____		Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you on birth control? <input type="checkbox"/> Yes, type: _____		<input type="checkbox"/> No
Are you interested in birth control? <input type="checkbox"/> No <input type="checkbox"/> Yes, type: _____		

Do you have a living will or Advance Directive?  Yes  No If no, would you like one?  Yes  No

Do you have a Declaration for Mental Health?  Yes  No If no, would you like one?  Yes  No

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**PREVENTIVE CARE**

Date/place of last <b>PAP smear</b> : _____ History of Abnormal PAP? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last <b>colon cancer screening</b> : _____ Type: <input type="checkbox"/> Stool Card <input type="checkbox"/> FIT kit <input type="checkbox"/> Colonoscopy Any abnormal results? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last <b>HbA1c</b> : _____ Value: _____ %	Date of last <b>PSA (prostate level)</b> ? _____ Do you perform monthly testicular exams? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last <b>mammogram</b> : _____ Results normal? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you perform monthly breast exams? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last <b>cholesterol screening</b> : _____
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**ALLERGIES** (*List food, medication, environmental allergies and reactions*)


**MEDICATIONS** (*List all prescriptions, over the counter medications, vitamins, herbs*)

Check here if medications given on a separate sheet or list

Name	Dose (mg)	Frequency	Reason

**SAFETY / HEALTH HABITS**

**Do you use tobacco/nicotine products?**  
 Yes  No  Quit, date: \_\_\_\_\_  
 Cigarettes, per day: \_\_\_\_\_  
 Chew  E-cigarette / vape  
 Are you interested in quitting? \_\_\_\_\_

**Do you consume alcohol?**  
 Yes  No  Quit, date: \_\_\_\_\_  
 How much per day? \_\_\_\_\_

**Do you use marijuana?**  Yes  No  
**Do you use CBD?**  Yes  No

**Do you use recreational drugs?**  
 Yes  No  Quit, date: \_\_\_\_\_

**Do you exercise?**  Yes  No  
 How often? \_\_\_\_\_  
 What type(s)? \_\_\_\_\_

**How much sleep do you get?** \_\_\_\_\_ hrs

Signature (Patient / Legal Guardian): \_\_\_\_\_ Date: \_\_\_\_\_