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:

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

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 6th 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 case, 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. 6th 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

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. 6th Street
Klamath Falls, OR 97601
541-930-7835
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 (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. Kaaloḳ 1-541-851-8110

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

ကြမာန်မာ (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

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.

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

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

Name: _____ Relationship: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

GUARANTOR / RESPONSIBLE PARTY

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

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.

_____

_____

_____

_____

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**/Immuniaciones ____ **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 envié 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 destinario 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/**Inciale**s) _____**

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
Minor / Pediatric / School-based Health Center (0-18 years old)

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)*

☐Acne	☐Depression	☐Hearing problems	☐Sickle-cell Anemia
☐ADD / ADHD	☐Developmental delay	☐Heart murmur	☐STDs / STIs
☐Allergies (seasonal)	☐Diabetes	☐Heart problems (Arrhythmia/A-Fib)	☐Strep throat (recurrent)
☐Anemia	☐Eating disorder	☐Immune deficiency	☐Thyroid disease
☐Anxiety	☐Eczema	☐Migraines	☐Tuberculosis (When: _____)
☐Asthma	☐Epilepsy / Seizures	☐Meningitis	☐Urinary tract infections
☐Blood clots	☐Glasses / contacts	☐Pneumonia (When: _____)	☐Vision problems
☐Concussion	☐Headaches	☐Scoliosis	☐Other: _____

☐Broken Bones, in last year (Where: _____) ☐Varicella (Chicken pox) (When: _____)

☐Cancer (Type: _____) ☐Other: _____

SURGERIES / HOSPITALIZATION

Date	Type / Reason

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

Problem	Relation	Age	Type
Anemia			
Asthma / COPD			
Cancer			
Depression			
Diabetes			
Heart disease			
High blood pressure			
Kidney problems			
Stroke			
Other			

REPRODUCTIVE HEALTH

Age periods started: _____ Last menstrual period: _____

Is patient on birth control? ☐Yes, type: _____ ☐No

Is patient interested in birth control? ☐Yes, type: _____ ☐No

IMMUNIZATIONS

Do you believe you/your child is up-to-date on all recommended immunizations? ☐ Yes ☐ Not sure

Do you have a copy of your/your child's current immunization record? ☐ Yes ☐ Not sure

Any reactions or problems to previous immunizations/vaccines? ☐ Yes ☐ No

If yes, please describe: _____

.

Patient Name: _____ Birth Date: _____ Today's Date: _____

ALLERGIES *(List all food, medication, environmental allergies, dates, and reactions where possible)*

Does patient have allergies? ☐Yes ☐No Has allergy testing been done? ☐Yes ☐No

MEDICATIONS *(List all prescriptions, over the counter medications, vitamins, herbs. OK to include separate sheet)*

Name	**Dose** (mg)	**Frequency**	**Reason**

FAMILY HISTORY / HOME ENVIORNMENT (*Write in, circle or check the answers below.)*

Mother's Name: _____ Biological / Step / Adoptive / Foster | Lives with child ☐Y ☐N

Father's Name:_____ Biological / Step / Adoptive / Foster | Lives with child ☐Y ☐N

Other (name & relationship): _____

Siblings (at home, first names & ages): _____

Are there tobacco users/smokers in the home? ☐Y ☐N Does anyone in the home use alcohol/drugs often? ☐Y ☐N

Are there any guns/firearms in the home? ☐Y ☐N Is anyone in the home being hurt or touched in a bad way? ☐Y ☐N

BIRTH HISTORY (*Write in, circle or check the answers below.)*

Pregnancy was: Full Term \ Early \ Late | Lasted: _____ weeks *(full term is 40)* | Birth weight: ____ pounds ____ ounces

Pregnancy complications: _____

Birth complications: _____

Tobacco / Alcohol / Drug use in pregnancy? ☐Yes ☐No | Baby's hearing screen passed? ☐Yes ☐No

Hospital stay lasted: ☐1-3 days & routine ☐Prolonged 4+ days due to: _____

SOCIAL HISTORY (*Write in, circle or check the answers below.)*

What school do you/your child attend? _____

Who is your primary care provider (if not KHP)? _____

Date of last dental visit: _____ Does patient feel safe at home? ☐Yes ☐No

Does patient smoke? ☐Yes ☐No Does patient vape? ☐Yes ☐No

Does patient use marijuana? ☐Yes ☐No Is patient sexually active? ☐Yes ☐No

Signature (Patient / Legal Guardian): _____ Date: _____