Shortgrass

COMMUNITY HEALTH CENTER, INC.

New Patient Welcome Packet

PAGE NUMBER REFERENCE

TO OUR VALUED PATIENTS:

Absolutely NO SMOKING OR VAPING is allowed on our property. Thank you for your cooperation.

Welcome to Shortgrass Community Health Center, Inc. (SCHC)

We want to make your experience with us as comfortable and convenient as possible.

SCHC is a private, non-profit community health center providing comprehensive, primary, and preventative medical services to families and individuals, regardless of the ability to pay. We are striving to be a Patient Centered Medical Home (PCMH), which is an innovative program for improving primary care for our patient population. The program gives practice information about organizing care around patient needs, working in teams, and coordinating and tracking care over time.

Services provided at SCHC are medical, behavioral health, dental, vision, substance use disorder and addiction therapy, as well as 340b pharmacy. SCHC strives to be a one-stop shop for all family health needs.

SCHC strives to provide affordable quality health care to the residents of our service area. Our doctors and staff are committed to keeping you and your family healthy, at rates that you can afford. If you have medical coverage, our staff will continue to file claims to your insurance company, Medicaid, SoonerCare, or Medicare on your behalf. If you think you might be eligible for Medicaid/SoonerCare our staff will be available to help you with the process. In order to continue with our current level of services, it will be necessary to collect the necessary fee from all of our patients when services are received. This includes the co-pay from Medicare and private insurance, as well as the minimum fee for the sliding scale discount fee program.

For patients who do not have any type of medical coverage, our fees will continue to be discounted, based on family income and size. For those who qualify, a minimum fee will be charged for each service performed. (Ex: Office visit, lab, x-ray etc.) To qualify for the sliding fee discount schedule, patients are required to complete a sliding fee application annually and update information immediately if there are any changes to income or household size. Co-payments are based upon household income and family size. Proof of income will be required to evaluate the application. The application and all documentation must be submitted at first visit or you may be subject to full charges.

SCHC understands that some patients may find it difficult to pay for services when they are received. For patients experiencing sudden financial difficulties and are unable to make payment, please contact our finance department to make financial arrangements. SCHC strives to be understanding and work with patients who are faced with sudden financial hardships. SCHC is not a ‘free clinic’ and is fiscally responsible to maintain sound business practices and be fiscally responsible. We do believe in no patient being surprised by a bill for care and can identify what your responsibility will be for services provided at Shortgrass prior to your appointment. If you require a ‘good faith estimate’ prior to services, please ask the receptionist for a form to be completed with cost estimates.

Thank you for choosing us as your health care home!

CANCELLATION POLICY

Shortgrass Community Health Center, Inc. is glad you have chosen us to provide you and your family with excellent care. It is our policy to request that you make all changes or cancellations of your appointments 24 hours in advance. We understand that situations arise that may prevent you from giving us advanced notice. Please let us know as soon as possible and realize that we may have to reschedule you if you are more than 15 minutes late. This is in order to keep our providers on schedule and avoid delays for other patients. We ask all new patients to arrive at least 30 minutes prior to the appointment to complete all necessary paperwork. Multiple broken or late appointments will be noted and could result in broken appointment fees.

LOCATIONS

SCHC – Hollis Center (Family Practice, Pediatrics, Behavioral Health, Substance Use Disorder Treatment, Dental, Optometry, 340B Pharmacy, Psychiatry)
400 E. Sycamore Hollis, OK 73550
Main Phone: 580-688-2800
Fax Number: 580-688-2193
Hours: M-Th, 8:00 A.M.–5:00 P.M.
Friday, 8:00 A.M.–2:00 P.M.

SCHC – Altus Center (Family Practice, Pediatrics, Behavioral Health, Substance Use Disorder Treatment, Psychiatry)
101 S. Hudson
Altus, OK 73521
Main Phone: 580-301-6154
Fax Number: 580-301-6163
Hours: M-Th, 8:00 A.M.-5:00 P.M.
Friday, 8:00 A.M.-2:00 P.M.

SCHC – Sayre Mobile (Family Practice, Pediatrics, Behavioral Health, Substance Use Disorder Treatment, Psychiatry)
1505 Watts Street,
Sayre, OK 73662
Main Phone: 580-688-2800
Fax Number: 580-688-2800
Hours: M-Th, 8:00 A.M.-5:00 P.M.
Friday, 8:00 A.M. – 2:00 P.M.

SCHC Pharmacy
400 E. Sycamore Hollis, OK 735501
Main Phone: 580-688-2800
Fax Number: 580-688-2193
Hours: M-Th, 8:00 A.M.–5:00 P.M.
Friday, 8:00 A.M.–2:00 P.M.

SCHC – Granite (Coming Soon) (Family Practice, Pediatrics, Behavioral Health, Substance Use Disorder Treatment)
507 W 6th Street
Granite, OK 73547
Main Phone: 580-688-2800
Fax Number: 580-688-2193
Hours: M-Th, 8:00 A.M.-5:00 P.M.
Friday, 8:00 A.M. – 2:00 P.M.

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BILLING, PAYMENT, and REFERRAL INFORMATION

BILLING, PAYMENT, and REFERRAL INFORMATION

SCHC's ability to remain open and provide discounted services greatly depends on our ability to collect what fees we are required to charge, even when those fees are discounted. In order to have your charges discounted if you qualify, you ***MUST*** bring proof of income at the time of visit and complete the sliding fee discount application. If this information is not provided at time of appointment, you will be charged the full price for the appointment.

BILLING AND PAYMENT

SCHC provides services billed according to patient's ability to pay. All co-payments are collected at time of check in for the appointment. After sliding fee discounts are applied to charges, the patient is responsible for paying the remaining fees, if applicable. SCHC is **not a free clinic**. We will be happy to assist any patient with a payment plan if necessary.

GOOD FAITH ESTIMATE

It is the desire of SCHC for none of its patients to be surprised with an unexpected bill. We can offer a "good faith estimate" regardless of insurance or lack of insurance to any patient who requests it. SCHC will make every attempt in that "good faith estimate" to verify if our location is in or out of network. Any patient, can, upon request ask for a good faith estimate. If, at the end of the billing cycle, the estimate was more than the patient expected, the patient may request a review or revision of their bill. It is the desire of SCHC to rectify any disputes according to billing practices and current regulatory requirements. Such disputes should be taken to the CFO/CEO for review and reconciliation.

REFERRAL SITUATIONS

SCHC is a **primary care** clinic. When a provider determines it is necessary to refer a patient to a specialist, the patient is responsible for that bill, and/or making payment arrangements with that provider. SCHC is not responsible for, nor has any control over, charges and fees occurring from referrals to other clinics.

LAB and X-RAY

Please understand that although the services that we contract for through local hospitals are discounted, SCHC has no control over the bill a patient receives for reading those results or any additional costs the hospital may charge. A hospital is required by law to have every x-ray evaluated by a radiologist, and that radiologist's bill is separate from our services. It is the patient's responsibility to pay for these additional services as required by the hospital.

SCHC contracts with Lab Corp for discounts for certain lab tests. Lab fees will not have extra reading charges. The amount the patient pays includes the entire fee for those services and is due prior to receiving the lab service.

REGISTRATION

In order to make your visit with us as smooth and quick as possible, it is necessary for you to call for an appointment. If your appointment is for a routine or follow-up visit, you will speak with staff member to schedule an appointment.

If you are calling for an urgent situation, every effort will be made to make a same day appointment with your provider or the walk-in provider.

If you get sick when SCHC is closed, please call the SCHC after – hours phone (580) 688-2800 and follow instructions provided on what actions to take:

- **If it is an emergency, please call 9-1-1**

You must make sure you bring your identification card to each visit if you are covered by Medicaid, SoonerCare, Medicare, or private insurance. Please let us know if your insurance carrier or insurance eligibility changes, or if you have a change in address, phone number(s), or other pertinent information that affects your account. Bring your children'simmunization records to each of their appointments.

If you are taking medicine prescribed by another doctor, bring all medicine bottles with you to your appointment.

DISCOUNT DRUG PRICING AND MEDICATION REFILLS

DISCOUNT DRUG PROGRAM

If a patient qualifies for a free medication program, SCHC does attempt to assist patients with paperwork required so that they may receive their medication(s). It is **not** SCHC's sole responsibility to complete all necessary paperwork. The patient is expected to participate in completing certain paperwork for this service.

Due to SCHC's federally qualified status, we are able to purchase drugs at a significant discount over regular pharmacy pricing. This is based on a percentage (%) scale, therefore, when a drug costs less, there is a smaller discount.When a drug falls into the higher price range, the discount becomes much more significant. Please feel free to take our written prescription and compare prices before purchasing.

Although in most instances the 340B Discount Drug Program pricing is less, there could be instances where pricing is very close to the same at all pharmacies. Currently, the SCHC pharmacy participates in the 340B Discount Drug Program. Please ask staff for participating pharmacies.

REFILLS

You may call **your pharmacy** during their regular business hours to request a refill. Please have the pharmacy **FAX** therefill request to SCHC at (580) 688-2193. Please **allow at least 5 business days** for medication refills. If you wait until you are out of your medication, there may be a delay in refilling your prescription. Be sure to allow extra time for weekends and holidays. If you should run out of your medication on a weekend or holiday, there will be a delay in refilling your prescription until the center re-opens. Please have your pharmacy fax your refill request physician you use, and call your pharmacy prior to picking up your medication.

MEDICATION POLICY

The following policies are to ensure your safety, and our continued ability to treat you in the most effective way possible.Please read this carefully.

1. Medication must be taken only as prescribed by our physicians and you must notify our providers when medication is given to you by another person or physician.
2. Any medication that is lost, misplaced, stolen, destroyed, or finished early may be replaced at the discretion of theprovider.
3. You must not share, sell, or otherwise permit others to have access to these medications.
4. All prescriptions should be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed.
5. The prescribing physician and staff have permission to discuss diagnostic and treatment details with dispensing pharmacists or other professionals who provide your healthcare for the purpose of medication accountability.
6. Refills will be given only during regular office hours.
7. Refills of medication will be given at the discretion of the provider. The provider may ask you to come back into the clinic for a follow-up appointment before refills are given.
8. **CLASS II** medications need to be filled by the pharmacy within 5 days of being written. If your prescription expires you must return the prescription to our office before another prescription will be issued to you.
9. You must keep your scheduled appointments in a timely manner. If you fail to appear for an appointment, your medication may not be refilled.
10. You must provide us with 24 hours' notice to cancel an appointment. If you fail to provide this notice, you may be subject to the consequences listed in #9 above.
11. Random urine drug screens and/or pill counts may be requested. Presence of unauthorized substances, abnormal results or an inaccurate pill count may result in discontinuation of your controlled medications including, but notlimited to, opioid analgesics.

Your health care team at SCHC is dedicated to your safety and good health. This policy is designed to ensure your safety and to help us and you comply with the standards of good medical care, as well as state and federal laws.

Patient Rights and Responsibilities

All persons receiving services from Shortgrass Community Health Center, Inc. shall retain and enjoy all rights, benefits, and privileges the laws and constitution of the State of Oklahoma and the United States of America guarantee, except those specifically lost through due process. In addition, all persons shall have the right guaranteed by the Substance Abuse Client's Bill of Rights, unless an exception is specifically authorized by these standards or an order of a court of competent jurisdiction. Each Client/Consumer shall be notified of these guaranteed rights at admission. Should the Client/Consumer cannot understand the language in the Bill of Rights, an oral explanation shall be given in the language that the person can understand. Each person served by Shortgrass Community Health Center, Inc. can expect:

1. To be treated with respect and dignity from personnel who protect, promote and respect human dignity.
2. The right to be safe, sanitary and humane living or treatment environment.
3. The right to a humane psychological environment that protects him/her from harm, abuse, neglect, and/or exploitation.
4. To be provided services in an environment which provides reasonable privacy, promotes reasonable privacy, promotes personal dignity, and provides the opportunity for improved functioning.
5. The right to receive services or appropriate referral without discrimination as to race, color, age, gender, marital status, sexual orientation, religion, spiritual values, national origin, degree of disability, handicapping condition, legal status, and/or the ability to pay for services.
6. To never be neglected/and/or sexually, physically, verbally, or otherwise abused, harassed, humiliated or punished.
7. The right to be provided with prompt, competent, appropriate services and an individual treatment plan.
8. To be afforded the opportunity to participate in the treatment planning and consent, or refuse to consent to the proposed treatment unless these rights are abridged by a court on competent jurisdiction or in emergency situations defined by law.
9. The right to permit family members or significant others to be involved in their treatment and treatment planning.
10. The right to have their records treated in a confidential manner within 42 CFR part 2 and HIPAA regulations.
11. The right to review their records according to the policies and procedure set forth by Shortgrass Community Health Center, Inc. that are in accordance with State and Federal Laws including 42 CFR Part 2 and HIPAA regulations.
12. The right to refuse to participate in any research project or medical experiment without specific informed consent as defined by law and that such refusal shall not affect the services available to the person served.
13. The right to request the opinion of an outside medical or psychiatric consultant, at the expense of the person served.
14. The right to asset grievances with respect to any alleged infringement of these stated rights or any other granted rights.
15. The rights to never be retaliated against or subject to any adverse conditions or treatment services, solely or partially because of having asserted any of the person served rights listed in this document.
16. The right to have their funds managed in an ethical and appropriate manner that prohibits fiduciary abuse.
17. The right to mechanisms that will facilitate access and/or referrals to legal services, advocacy services, self-help groups, guardian, and conservators.
18. The right to be informed that services can be refused and that there could be consequences to refusal of services.
19. The right to an expression of choice of release of information.
20. The right of choice of concurrent services.

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable Federal and State Law to maintain the privacy of your health information. We are also required to give you this Notice of Privacy Practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 1/1/03 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us using this information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and other healthcare operations. For example:

Treatment: We may use or disclose your health information to a dentist, physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. By State Law, your authorization is valid for 90 days.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help you with your healthcare or with payment for your healthcare but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we may charge you $0.83 for each page up to thirty (30) and $0.63 for each page after thirty, a $19 administrative fee to locate and copy your health information and postage if you want the copies mailed to you. Radiographs (x-rays) will be duplicated at a reasonable fee. If you request alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last 6 years but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions but if we do, we will abide by our agreement (except in an emergency).

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternate locations. You must make your request in writing. Your request must specify the alternative means or locations and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. You request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances. Electronic Notice: If you receive this Notice on a website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Human Services.

Privacy Office: Shortgrass Community Health Center Administration
400 East Sycamore, Hollis, OK 73550
Telephone: (580) 688-2800
Fax: (580) 688-2193

CONSUMER NOTICE OF HEALTH INFORMAITON PRACTICES (HIPAA)

General Information

Information regarding your healthcare, including payment for healthcare, is protected by two (2) federal laws: The HealthInsurance Portability and Accountability act of 1996 ("HIPAA") 42, U.S.C. S132Od Confidentiality Law 42, U.S.C.290dd-2 C.F.R. Part 2. Under these laws, SCHC, may not say to a person outside of SCHC that you attend the program or clinic, nor may SCHC disclose any information identifying you as an alcohol or drug abuser, or any patient, or disclose any other protected information except as permitted by federal law.

SCHC must obtain your written consent before it can disclose information about you for payment purposes. For example, SCHC must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you also sign a written consent before SCHC can share information for treatment purposes or healthcare operations; however, federal law permits SCHC to disclose information without your written permission in the following instances:

1. Pursuant to an agreement with a qualified service organization/business associate.
2. For research, audit, or evaluation.
3. To report a crime committed on SCHC's premises or against SCHC's personnel.
4. To medical personnel for medical emergency.
5. To appropriate authorities to report suspected child and elder abuse or neglect.
6. As allowed by court order.

For example, SCHC can disclose information without your consent to obtain legal and financial services, or to a medical facility to provide healthcare to you, as long as there is a qualified service/organization/ business associate agreement in place. Before SCHC can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing.

Your Rights:

Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health information. SCHC is not required to agree to any restrictions you request, but if it does agree it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.

You have the right to request that we communicate with you by alternative means at an alternative location. SCHC will accommodate such requests that are reasonable and will not request an explanation from you. Under HIPAA you also have the right to inspect and copy your own healthcare information maintained by SCHC except to the extent that the information contains counseling notes or information compiled for use in a civil, criminal, or administrative hearing or in other limited circumstances. Under HIPAA, you also have the right, with some exceptions, to amend healthcare information maintained in SCHC's records, and to request and receive an accounting of disclosures of your health related information made by SCHC during the past six (6) years prior to your request. You also have the right to receive a paper copy of this notice.

SCHC Duties

SCHC is required by law to maintain the privacy of your health information and to provide you with notice of its legalduties and privacy practices with respect to your health information. SCHC is required by law to abide by the terms of this notice. SCHC reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. Such changes will be communicated to present clients through provision of a copy of the revised notice. Former clients making appropriate requests will be provided a copy of the updated notice at the time of request.

Complaints and Reporting Violations

You may complain to SCHC and the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated under HIPAA. Such complaints should be pursued through the established SCHC grievance procedures. You will not be retaliated against for filing such a complaint.

Violation of the Confidentiality Law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United States District Attorney in the district where the violation occurs.

PATIENT CENTERED MEDICAL HOME (PCMH) AGREEMENT

Shortgrass Community Health Center, Inc. (SCHC) wants to be YOUR Medical Home. Our goal at SCHC is to provide patient centered care to all its patients. Patient centered care means your medical provider, Health Care Team, patient and families work together to provide quality care to YOU. We do this through patient and family communication where the needs and preferences of the patient are communicated to your SCHC Health Team. Your SCHC Health Care Team may include your medical provider – a doctor, nurse practitioner, or physician's assistant and your nurse, dietician, lab, x-ray, dentist, optometrist, pharmacist and behavioral health specialist. In turn we will listen to these needs and focus their education and training to make sure YOU get good quality health care.

Our plan:

SCHC and the patient/parent will achieve this patient centered care based on these items that we agree upon.

- SCHC will provide quality health care to the best of our ability and knowledge in a safe environment.
- Patients and their families have the ability to ask questions and voice concerns through an open channel ofcommunication with our Health Team.
- The patient/parent is honest in the history of symptoms. Your Health Team is open and honest in relating thediagnosis and related treatment. It is important for the patient/parent to disclose all symptoms or medical problems at the time of treatment.
- The patient/parent is agreeable with your treatment plans. SCHC will provide clean and understandableinstructions.
- SCHC will provide patient with enough time during their office visit to make sure the medical problem is understood and the treatment plan is thoroughly explained. Both the patient/parent and your Health Team willrespect one another's time.
- The patient/parent will pay for their share of the services rendered not covered by their insurance at the time of theoffice visit. It is the patient/parent responsibility to know their insurance benefits.
- SCHC offers same day appointments for acute care and allots reasonable times for follow-up, preventative care and disease management appointments.
- SCHC may refer patient to a specialist or suggest certain tests/procedures that are not done in the office butinstructions will be given for any referral. It is the patient/parent responsibility to find out if the specialist is covered by their insurance.
- SCHC is not responsible for costs for patient specialty care or tests/procedures recommended by ourproviders.
- SCHC will make the referral; however, it is the responsibility of the patient/parent to follow-up with thereferral and understands the insurance coverage for the specific referral.
- SCHC will give results of lab/x-ray tests by calling and/or mailing the patient/parent. The patient/parentshould call the office if not notified about test results in an appropriate time frame.
- The patient/parent shall do their best to participate in health habits and lifestyles.
- SCHC may provide educational health information. The patient/parent can use this information and ask questions if needed.
- The patient/parent should keep their appointments; a missed appointment takes up time that another patient coulduse.
- The patient/parent should arrive on time for their scheduled appointment. SCHC in turn will work to stay onschedule.
- SCHC will respect the patient/parent individually. We will not make judgments based on race, religion,gender, gender identity, age or disability.
- SCHC will respect patient/parent privacy. Medical information will not be shared with anyone unless it is vital for treatment, payment or health care operations, you give us permission, or it is required by law or court order.
- SCHC has computer prescription programs with most pharmacies. Prescriptions are sent to your specified pharmacy electronically, otherwise, a printed prescription will be provided.
- This agreement that describes your SCHC Health Care Team relationship with YOU has been given to and received by a patient/parent for his or her Health Team member today.

Shortgrass
COMMUNITY HEALTH CENTER, INC.

Welcome to Shortgrass Community Health Center

The amount that you will be responsible for paying will be determined using a Sliding Scale Discount Schedule which is based on your total income as it relates to the Federal Poverty Level (FPL) Guidelines for this year. The sliding scale discount schedule is included in this notice.

Documentation of income and number in household must be provided to the Shortgrass Community Health Center business office to determine the eligibility and amount of discount for services to be provided.

ALL PATIENTS WILL BE SEEN REGARDLESS OF ABILITY TO PAY.

A nominal fee of $10 is requested for services in medical, behavoral health, and vision clinics and $20 for services provided in dental clinics for patients at or below the 100% FPL. All other patients will have a co-pay or minimal fee based upon their insurance carrier or their annual income.
Routine lab services are offered on a sliding scale basis but not included in the nominal fee.

Any attempt to falsify information relating to income or other elgibility requirements is a violation of federal law and is subject to prosecution.

N0 PATIENT WITH INCOME GREATER THAN 200% FPL IS ELIGIBLE FOR THE DISCOUNT.

The Shortgrass Community Health Center Sliding Scale Discount Schedule is based on the current annual Federal Poverty Level (FPL) guideline and is updated in the EMR by the billing manager.

Shortgrass Community Health Center

2026 Sliding Scale Discount Schedule

Category	Slide	S1	S2	S3	S4	S5
% of Federal Poverty Level (FPL)		<= 100%	101 - 125 %	126 - 150%	151 - 175%	176 - 200%
Patient Nominal Fee	Medical/BH/Vision/Psych	$10	$20	$30	$40	$50
	Dental	$20	$30	$40	$50	$60
	Enabling Services	$1	$2	$3	$4	$5
Family Size						
1	**Annual (Up to)**	**$15,960**	**$19,950**	**$23,940**	**$27,930**	**$31,920**
	Monthly	$1,330	$1,663	$1,995	$2,328	$2,660
	Weekly	$307	$384	$460	$537	$614
	Hourly	$8	$10	$12	$13	$15
2	**Annual (Up to)**	**$21,640**	**$27,050**	**$32,460**	**$37,870**	**$43,280**
	Monthly	$1,803	$2,254	$2,705	$3,156	$3,607
	Weekly	$416	$520	$624	$728	$832
	Hourly	$10	$13	$16	$18	$21
3	**Annual (Up to)**	**$27,320**	**$34,150**	**$40,980**	**$47,810**	**$54,640**
	Monthly	$2,277	$2,846	$3,415	$3,984	$4,553
	Weekly	$525	$657	$788	$919	$1,051
	Hourly	$13	$16	$20	$23	$26
4	**Annual (Up to)**	**$33,000**	**$41,250**	**$49,500**	**$57,750**	**$66,000**
	Monthly	$2,750	$3,438	$4,125	$4,813	$5,500
	Weekly	$635	$793	$952	$1,111	$1,269
	Hourly	$16	$20	$24	$28	$32
5	**Annual (Up to)**	**$38,680**	**$48,350**	**$58,020**	**$67,690**	**$77,360**
	Monthly	$3,223	$4,029	$4,835	$5,641	$6,447
	Weekly	$744	$930	$1,116	$1,302	$1,488
	Hourly	$19	$23	$28	$33	$37
6	**Annual (Up to)**	**$44,620**	**$55,775**	**$66,930**	**$78,085**	**$89,240**
	Monthly	3,718	4,648	5,578	6,507	7,437
	Weekly	$858	$1,073	$1,287	$1,502	$1,716
	Hourly	$21	$27	$32	$38	$43
7	**Annual (Up to)**	**$50,040**	**$62,550**	**$75,060**	**$87,570**	**$100,080**
	Monthly	$4,170	$5,213	$6,255	$7,298	$8,340
	Weekly	$962	$1,203	$1,443	$1,684	$1,925
	Hourly	$24	$30	$36	$42	$48
8	**Annual (Up to)**	**$55,720**	**$69,650**	**$83,580**	**$97,510**	**$111,440**
	Monthly	$4,643	$5,804	$6,965	$8,126	$9,287
	Weekly	$1,072	$1,339	$1,607	$1,875	$2,143
	Hourly	$27	$33	$40	$47	$54
	*	$5,680	$5,680	$5,680	$5,680	$5,680

IMPORTANT: *For Family Units over 8, add the amount shown for each additional family member.

Application for Sliding Fee

Shortgrass Community Health Center offers patients a discount on their medical bills if they qualify for our sliding fee scale. The discount is based on the **GROSS** income of **ALL** members of the household and the number of members in the family. If you want to apply for this discount we need income verification. **Proof of income is required.**

(Examples: most recent pay stub, prior year's W-2 forms, tax returns, bank statement showing deposits, letter of income from employer, attestation letter from someone not a household member, self-attestation letter.)

Please list ALL family members: (*Frequency = Weekly, Biweekly, Bimonthly, Monthly, or Annual*)

Name	Date of Birth	Income	Frequency

** **Patients applying for the sliding fee program are obligated to contact SCHC if their income or household status changes, or if they become eligible for insurance. Patients must update information on an annual basis to remain on the sliding fee program.**

AFFIDAVIT

By signing below, I attest that, as of the date of my signature, the income sources listed constitute all of my household income, and that the family members listed are all solely dependent on that income, or that the explanation provided to verily my income level is truthful. I understand that I have 30 days to provide proof on income or I will be responsible for promptly paying the full charge of all visits.

***APPLICANT SIGNATURE*_____*DATE*_____

Sliding Scale Discount (FOR OFFICE USE ONLY)

Total household WEEKLY income_____ Total # household members_____

Total household BIWEEKLY income _____ **Staff calculations**

Total household BIMONTH income _____

Total household MONTHLY income _____

Total household ANNUAL income _____

VALID from: _____TO _____ _____

(month/day/year) (month/day/year) (Authorized Office Staff Signature)

Income Category: ☐<=100% ☐101-150% ☐151-200% ☐over 200% Sliding fee calculator completed: ☐

New Patient Registration Form

Shortgrass COMMUNITY HEALTH CENTER, INC.

As a Federally Qualified Health Center, SCHC is required to collect demographic information regarding the patients we serve to support our clinic funding. The information you provide is confidential. Please check 'Not Reported/Refused' if you do not wish to answer a specific question. Thank you for choosing SCHC as your health care provider.

Section 1: Patient Information

First Name: _____ **Middle Name:** _____ **Last Name:** _____ **Suffix:**_____

Date of Birth: _____ **SSN:**_____ **Sex:** ☐M ☐F **Marital Status:** ☐Single ☐Married ☐Widowed

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

Email: _____ **Primary Phone:** _____ ☐ Home ☐ Work ☐Cell

Primary Language: ☐ English ☐ Spanish ☐ Sign Language ☐ Other _____ ☐Translator needed

Employment status: ☐Full time ☐Part time ☐Student ☐Unemployed ☐Disabled ☐Retired ☐ Not Reported/Refused

Education: ☐Student ☐ High school ☐Undergraduate ☐ Higher ☐ Not Reported/Refused

Race: ☐Caucasian ☐African American ☐American Indian or Alaska Native ☐Asian Indian ☐Chinese ☐Filipino ☐Japanese ☐Korean ☐Vietnamese ☐Other Asian ☐Native Hawaiian ☐Guamanian or Chamorro ☐Samoan ☐Other Pacific Islander ☐Other_____ ☐ Not Reported/Refused

Ethnicity: ☐ Non-Latino/Non-Hispanic ☐ Latino/Hispanic ☐Puerto Rican ☐Cuban ☐Mexican, Mexican American, Chicano/a ☐ Not Reported/Refused ☐Other_____

Are you a (*please check all that apply*)….? ☐ Veteran ☐ Migrant Farm Worker ☐ Seasonal Farmworker ☐ Homeless/unhoused

Income Category	1	2	3	4
Family Size	Annual Income (Up to)	Annual Income (Up to)	Annual Income (Up to)	Annual Income
1	$15,650	$23,475	$31,300	$31,300 or greater
2	$21,150	$31,725	$42,300	$42,301 or greater
3	$26,650	$39,975	$53,300	$53,301 or greater
4	$32,150	$48,225	$64,300	$64,301 or greater
5	$37,650	$56,475	$75,300	$75,301 or greater
6	$43,150	$64,725	$86,300	$86,301 or greater
7	$48,650	$72,975	$97,300	$97,301 or greater
8	$54,150	$81,225	$108,300	$108,301 or greater

IMPORTANT: *For Family Units over 8, add $5,500 per person.

Referring to the table, please list the number of members in your household & income category:

List # of Family Members:

Please check the income category for your household:

☐ 1 ☐ 2 ☐ 3 ☐ 4

☐ **Decline to disclose**

Section 2: Guarantor/Insurance (Financially Responsible Individual) Information

Patient's Relation to Guarantor: ☐ Self **(skip to Plan 1 Information)** ☐ Child ☐ Parent ☐ Spouse ☐ Employer ☐ Other_____

First Name: _____ **Middle Name:** _____ **Last Name:** _____ **Suffix:**_____

Date of Birth: _____ **SSN:**_____ **Sex:** ☐M ☐F **Marital Status:** ☐Single ☐Married ☐Widowed

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

Plan 1 Information

Insurance Company: _____ **Group Number:** _____ **Claim Member ID:** _____

Plan 2 Information

Insurance Company: _____ **Group Number:** _____ **Claim Member ID:** _____

Section 3: Preferred Pharmacy

Pharmacy Name:_____ **Phone Number:**_____ **City:**_____ **State:**_____

Section 4: Treatment and Payment Authorization

You are responsible for your own bill. As a courtesy, SCHC will submit charges to your insurance carrier. If you have no insurance, you will be required to set up payment arrangements with our finance office. I hereby assign, transfer, and set over to SCHC all of my rights, title, and interest to my medical reimbursement benefit under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I, revoking said authorization, give written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I, the undersigned, agree to participate in clinical interviews, treatment, and testing as a patient of SCHC. I authorize treatment for my identified minor or myself. I also understand that examination and treatment may be by a student, intern, or resident under the supervision of a clinician.

☐ **I agree to abide by SCHC treatment and payment authorization policy.**

Notice of Privacy Practices

☐ I have been given, read, and understand the Notice of Privacy Practices of SCHC.

☐ I have refused my copy of the Notice of Privacy Practices.

Patient/Guardian Signature: _____ **Date:** _____

Patient Name: _____ **Date of birth:** _____

Reason for Visit:

Allergies:

Medical Conditions:

Surgeries:

List All Medications and Dosages:

Family History:

Are you a smoker? ☐ **Yes** ☐ **No** **If yes, would you like assistance with quitting?** ☐ **Yes** ☐ **No**

Do you use either alcohol or drugs, including marijuana? ☐ **Yes** ☐**No** **If yes, please list the type of substance used and how often it is used:**_____

We ask everyone about their reproductive health needs. Do you want to talk about contraception or pregnancy prevention during your visit today? ☐ **Yes** ☐ **No**

Alternative Contact Authorization

This authorization allows SCHC providers and staff to communicate information regarding your medical care to the individual(s) you designate. As part of SCHC's Patient Privacy Policy, SCHC will release your health information only as you specifically authorize. Please check whether you DO or DO NOT authorize SCHC to release your health information. Please complete the contact information portion only for individuals authorized to receive your health information.

☐ **I DO NOT authorize** anyone to receive information regarding my medical care**.**

☐ **I DO AUTHORIZE** providers and staff of SCHC to release information regarding my medical care.

Contact #1 ☐ Patient lives with this contact

Name:_____ **Relationship:**_____

Phone: _____ ☐ All Information ☐ Emergencies only ☐ Appointments ☐ Financial Account ☐ Test Results ☐ Other: _____

Contact #2 ☐ Patient lives with this contact

Name:_____ **Relationship:**_____

Phone: _____ ☐ All Information ☐ Emergencies only ☐ Appointments ☐ Financial Account ☐ Test Results ☐ Other: _____

Consent to Treat a Minor

The Minor Treatment Consent Form gives our providers permission to treat your child when he or she is in someone else's care. Please list the person's name, phone number, and his/her relationship to your child in the space provided.

I, _____, the legal parent/guardian of _____(Minor's Name), grant permission to the following individual(s) to request and approve medical care for the above named minor:

Name: _____Relationship to child: _____Phone:_____

Parent/Legal Guardian Signature:_____ Date: _____

SCHC Witness Signature:_____Date: _____

Client Name: _____ Date of Birth: _____

Shortgrass Community Health Center

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

☐ **Receiving** ☐ **Disclosing**

Shortgrass Community Health Center: Mental Health

Name, Title

400 E. Sycamore Hollis, OK 73550

Site Address

580-688-2800

Phone

☐ **Receiving** ☐ **Disclosing**

Name, Title

Site Address

Phone

☐ **Assessment** ☐ **Treatment Plan** ☐ **Other Clinical Documentation** ☐ **Testing** ☐ **Behavioral Report**

☐ **Discharge Information** ☐ **Other Information Pertinent to:** _____

IE: dental care, medical care etc.

The Purpose of This Request is:

This authorization will expire on: _____ **(must be updated after 365 calendar days) OR when the following event occurs: Upon discharge if before the year expiration.**

Treatment is not contingent on signing this release

I hereby authorize the use or disclosure of my protected health information as specified above. This authorization permits disclosure of information about mental illness or substance abuse conditions and other health conditions and information. I understand that this authorization is voluntary and that I may refuse to sign it. **I understand that I may revoke this authorization at any time by giving written notification to my provider or any member of the office staff. My revocation will not affect any action taken in reliance on the authorization before the revocation.** I understand that, if the receiver of information is not a health care provider or a health plan, the information disclosed under this authorization may no longer be protected by state and federal privacy regulations and may be re-disclosed by the recipient. I understand that I should receive a copy of this authorization, even if I do not ask for it.

In compliance with CFR 42, part 2, § 2.22 and O.S 43A, section 1-102, 1-103
Confidentiality of Patient Records

The confidentiality of patient records maintained by this program is protected by State and Federal law and regulations. Generally, the program may not say to a person outside of the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser UNLESS:

1) The patient consents in writing:
2) The disclosure is allowed by a court order; or
3) The disclosure is made to medical personnel in a medical emergency or to a qualified personnel for research, audit, or program evaluation.

Violation of the State and Federal law and regulation by a program is a crime. Suspected violations may be reported to appropriate authorization in accordance with State and Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or Federal laws and regulations do not protect any who works for the program or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

"The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). (63 O.S. P 1-1502(B)"

Non-contingency statement: I understand that my failure to sign this form will not result in the withholding of services.

_____ _____

Client Signature (if client is 14 or older) Date

_____ _____

Parent/Guardian Signature (if under 18 or in custody) Date

Shortgrass
COMMUNITY HEALTH CENTER, INC.

Treatment and Payment Authorization

You are responsible for your own bill. As a courtesy, SCHC will submit charges to your insurance carrier. If you have no insurance, you will be required to set up payment arrangements with our finance office.

- I hereby assign, transfer, and set over to SCHC all of my rights, title, and interest to my medical reimbursement benefit under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I, revoking said authorization, give written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

- I, the undersigned, agree to participate in clinical interviews, treatment, and testing as a patient of SCHC.

- I authorize treatment for my identified minor or myself. I also understand that examination and treatment may be by a student, intern, or resident under the supervision of a clinician.

_____ _____

Patient/Guardian Signature Date

Notice of Privacy Practices

☐ I have been given, read, and understand the Notice of Privacy Practices of SCHC.

☐ I have refused my copy of the Notice of Privacy Practices.

_____ _____

Patient/Guardian Signature Date

_____ _____

Witness Signature Date

Shortgrass
COMMUNITY HEALTH CENTER, INC.

ACKNOWLEDGMENT OF RECEIPT OF SCHC WELCOME PACKET

Please initial beside each item that you have received in writing and understand the items contained in the welcome packet. If you at any time have questions, please ask for assistance from our front desk employees.

_____ Cancellation Policy

_____ Locations

_____ Billing, Payment and Referral Information and Registration

_____ Discount Drug Pricing and Medication Refills

_____ Medication Policy

_____ Patient Rights and Responsibilities

_____ Notice of Privacy Practice

_____ Consumer Notice of Health Information Practices (HIPAA)

_____ Patient Centered Medical Home Agreement (PCMH)

_____ SCHC Sliding Fee Scale Application

_____ SCHC Sliding Fee Scale

_____ _____

Patient or Patient's Representative Signature Date

_____ _____

Please Print Your Name Patient's Name

_____

Representative's Relationship to Patient

_____ _____

Verification Signature – SCHC Staff Date

For Office Use only

Patient # _____

Shortgrass
COMMUNITY HEALTH CENTER, INC.

Child Dental Questionnaire

In order to provide a complete dental exam for your child, please answer the following questions as completely as possible.

Date: _____/_____/_____

Child's Name: _____ Child's SSN: _____-_____-_____

Birthdate: _____/_____/_____ Age:_____ Sex: ☐ Male ☐ Female Nickname: _____

Father's Name: _____ Mother's Name: _____

Favorite Pet or Toy: _____ Pet's Name: _____

Is Child Adopted? ☐ Yes ☐ No Legal Guardian's Name: _____

Child's Physician: _____ Phone: (_____) _____-_____

Date of Last Physical Examination: _____/_____/_____

How is your child's general health? _____

Has your child had any serious illness? ☐ Yes ☐ No If yes, describe: _____

Has your child ever been hospitalized? ☐ Yes ☐ No If yes, for what reason: _____

Is your child receiving any medication at this time? ☐ Yes ☐ No If yes, describe: _____

Has your child ever had an allergic reaction to the following: ☐ Dental Anesthetics ☐ Antibiotics ☐ Food ☐ Drugs ☐ Latex

Please describe: _____

Has your child ever received a blow or injury to his head or teeth? ☐ Yes ☐ No If yes, describe: _____

Has your child ever been treated with X-ray or radiation therapy? ☐ Yes ☐ No

---

Has your child ever had any of the following conditions? *Please check:*

	Yes	No			Yes	No			Yes	No	
Heart Disease	☐	☐	Age _____	Aids or HIV	☐	☐	Age _____	TB (Tuberculosis)	☐	☐	Age
Heart Murmur	☐	☐	Age _____	Bleeding Problems	☐	☐	Age _____	Sickle Cell Anemia	☐	☐	Age
Rheumatic Fever	☐	☐	Age _____	Lung Disease	☐	☐	Age _____	Disease ☐ or ☐ Trait			
Diabetes	☐	☐	Age _____	Liver Disease	☐	☐	Age _____	Other (Please describe): _____			
Scarlet Fever	☐	☐	Age _____	Learning Disability	☐	☐	Age _____	_____			
Kidney Disease	☐	☐	Age _____	Emotional Disturbance	☐	☐	Age _____	_____			
Epilepsy	☐	☐	Age _____	Mental Retardation	☐	☐	Age _____	_____			
Asthma	☐	☐	Age _____	Mononucleosis	☐	☐	Age _____	_____			
Hepatitis	☐	☐	Age _____	Hearing Problems	☐	☐	Age _____	_____			

Does your child have any habits we should know about, such as? ☐ Poor Eating Habits ☐ Thumb Sucking ☐ Pacifier ☐ Bottles

Does your child receive fluoride in: Drinking Water at Home? ☐ Yes ☐ No By Prescription? ☐ Yes ☐ No

Has your child had any unpleasant dental experiences? ☐ Yes ☐ No How can we help? _____

Date of last dental examination: _____/_____/_____

Has your child ever had orthodontic treatment? ☐ Yes ☐ No If yes, when: _____/_____/_____

What is the nature of today's visit? ☐ Regular Exam ☐ Emergency (state problem: _____)

I understand the above information is necessary to provide me with dental care in a sale and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

I consent to the doctor's exam and necessary diagnostics tor treatment including x-rays.

Signature of Parent or Guardian: _____

Welcome and thank you for letting us care for your child's smile!

CHILD DENTAL HISTORY NAME: _____ #: _____

Shortgrass
COMMUNITY HEALTH CENTER, INC.

Informed Consent Form for General Dental Procedures

Please initial for consent in the box provided.

	Examination and X-Rays: I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.
	Local Anesthesia: Anesthetizing agents are injected into a small area or injected as a nerve block directly into a larger area of the mouth with the intent of numbing the area to receive dental treatment. Risks include but are not limited to infection, swelling, allergic reactions, hematoma, bruising, discoloration, headache, tenderness at the needle site, dizziness, nausea, vomiting, and cheek/tongue/lip biting can occur from the injection. It is normal for the numbness to take time to wear off after treatment, usually 2-3 hours. However, it can take longer, and rarely the numbness is permanent if the nerve is injured
	Drugs, Medications & Sedation: I have been informed and understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I understand that failure to take medications prescribed for me in the manner prescribed may increase risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.
	Changes in Treatment Plan: I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on my teeth that were not discovered during the examination. The most common being root canal therapy following routine restorative procedures. I give my permission to Dr. Lively to make any changes and additions as necessary.
	Temporomandibular Joint Dysfunctions (TMD): I understand that symptoms of popping, clicking, locking, and pain can intensify or develop in the joints of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMD associated with dental treatment are usually transitory in nature and well-tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.
	Fillings: I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage, and tooth sensitivity is a common after-effect of newly placed fillings.
	Removal of Teeth (Extraction): I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (paraesthesia) that can last for an indefinite period of time or a fractured jaw. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment. The cost of which is my responsibility.
	Crowns, Bridges, and Bonding: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily, and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes to my new crown, bridge, or cap (including shape, fit, size, placement, and color) will be done before cementation after which additional fees may apply. It has been explained to me that in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

	Dentures - Complete or Partial: I realize that full or partial dentures are artificial, constructed of plastic, metal, acrylic, and/or porcelain. The problems of wearing those appliances have been explained to me including but not limited to looseness, soreness, and possible breakage. I realize that the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be a "teeth in wax" try-in visit. I understand that immediate dentures require relining approximately three to twelve months after initial placement and the cost of relining is not included in the initial denture fee.
	Endodontic Treatment (Root Canal): I realize there is no guarantee that root canal treatment will save my tooth. I realize that complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).
	Periodontal Treatment: I understand periodontitis (gum disease) is a serious condition causing gum inflammation and/or bone loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery and/or extractions. I understand the success of treatment depends in part on my efforts to brush and floss daily, receive regular cleanings as directed, follow a healthy diet, avoid tobacco products, and follow other recommendations.

CONSENT

I understand that the doctor is not responsible for previous dental treatment. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that no guarantees of results or absolute satisfaction are possible with dental treatment. I have truthfully answered all questions about my medical history and present health condition fully and truthfully. I have told Dr. Lively or other office personnel about all conditions, including allergies, which might indicate that I should receive oral medications and/or anti-anxiety agents. I will not hold Dr. Lively or associates responsible for any errors or omissions I may have made. I also understand if I ever have any changes in health status or in medication(s), I need to inform the doctor at the next appointment. I authorize Dr. Lively to forward a review of findings and/or any other necessary dental information to the referring doctor for his/her records, as well as any third parties such as insurance companies who may request information. I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All of my questions have been answered by Dr. Lively in a satisfactory manner and I believe I have all of the necessary information to give informed consent for treatment. I further understand that this consent shall remain in effect until terminated by me.

Patient Signature and Date: _____

Print Patient Name: _____

Parent/Legal Guardian Name and Date: _____

Witness Sign and Date: _____