New Patient Welcome Packet

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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, psychiatry, 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!

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.

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.

CANCELLATION & NO-SHOW 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. If you/the patient miss more than three consecutive appointments in twelve months, we may need to pause your ability to schedule future visits for the next 6 months but you will still be able to call for a same-day visit. We will do our best to help you. Please know that this policy will not result in losing your provider at SCHC—we are here for you and will continue to provide care. Thank you for helping us provider care for everyone who needs it.

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.

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 the provider.
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 yoursafety 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.

If you have any questions about this Notice, please contact the Shortgrass Community Health Center's Privacy Officer at: (580) 688-2800.

WHO WILL FOLLOW THE PRIVACY PRACTICES DESCRIBED IN THIS NOTICE

This Notice of Privacy Practices (Notice) describes the privacy practices of Shortgrass Community Health Center (SCHC) and its workforce members (including employees, contractors, physicians, nurses, other licensed or certified personnel, volunteers, and front desk, billing and administrative personnel) who have a need to use your health information to perform their jobs. It also applies to any individuals authorized to enter information into your SCHC record. Your other health care providers may have different policies regarding their use and disclosure of your health information created at their location.

ABOUT YOUR HEALTH INFORMATION

We understand that health information about you and your health is personal, and protecting your health information is important to us. We create a record of the care and services you receive at SCHC. We need this record to provide you with quality care and to comply

with certain legal requirements. At times, the law permits or requires us to use or disclose your health information for various reasons. Health information that the law permits or requires us to disclose may be further shared by recipients and is no longer protected by law or the safeguards and restrictions in place when it is in our possession.

This Notice applies to all of the records of your care generated by SCHC, whether made by SCHC personnel or other health care providers, whether stored and transmitted electronically or by other means. We are required by law to:

- Maintain the privacy of health information that identifies you (with certain exceptions);
- Give you this Notice of our legal duties and privacy practices with respect to health information we collect and maintain about you; and
- Follow the terms of this Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose health information without obtaining your prior authorization. Following each category is an explanation. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. There may be situations in which laws other than the HIPAA (such as laws governing a patient's substance use disorder records) prohibit or materially alter how we use or disclose your health information. In those situations, we will comply with the more stringent law. More restrictive laws are summarized in the section of this Notice below titled "Exception for More Restrictive Laws."

- **Disclosure at Your Request.** We may disclose health information when requested by you. This disclosure at your request may require a written Authorization by you.

- **For Treatment.** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, students, or other SCHC personnel who are involved in taking care of you at SCHC. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Additionally, the doctor may need to tell the social worker if you have diabetes so we can arrange for appropriate follow up. Different areas of SCHC also may share health information about you in order to coordinate the different care you need, such as medications, lab work and x-rays. We also may disclose health information about you to people outside SCHC who may be involved in your healthcare after you leave SCHC, such as nurses, social workers, family members, or clergy. We may also use and disclose health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

- **For Payment.** We may use and disclose health information about you so that the treatment and services you receive at SCHC may be billed to and payment may be collected from you, an insurance company or a third party such as Workers Compensation. For example, we may need to give your health plan information about a procedure you received at SCHC so your health plan will pay us or reimburse you for the procedure or encounter. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your health plan will cover the treatment.

- **For Health Care Operations.** We may use and disclose health information about you for our health care operations activities. These uses and disclosures are necessary to operate SCHC efficiently and make sure that all of our patients receive quality care. For example, we may use health information to review the safety and the quality our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine and analyze health information about many SCHC patients to decide what additional services SCHC should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, students, volunteers and other SCHC personnel for review and learning purposes. Additionally, we may combine the health information we have with health information from other SCHCs to compare how we are doing and to see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of health information so others may use it to study health care and health care delivery without learning who the specific patients are.

ADDITIONAL USES AND DISCLOSURES OF HEALTH INFORMATION:

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

- **Directory.** We may include certain limited information about you in SCHC directory while you are a patient at SCHC. This information may include your name, location at our facility, general condition, and religious affiliation to clergy. Unless there is a specific written request from you to the Privacy Officer listed herein to the contrary, this directory information may also be released to people who ask for you by name.

- **Sign-in Sheet.** We may use and disclose health information about you by having you sign in when you arrive at SCHC. We may also call out your name when you are ready to be seen.

- **Appointment And Patient Recall Reminders.** We may use and disclose your health information to contact you to remind you regarding appointments or for health care that you are to receive.

- **Business Associates.** Some of our functions are accomplished through contracted services provided by Business Associates. A Business Associate may include any individual or entity that receives your health information from us in the

course of performing services for SCHC. Such services may include, without limitation, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services. When these services are contracted, we may disclose your health information to our Business Associates so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

- **DISASTER RELIEF.** We may disclose information about you to an entity assisting in disaster relief so that your family can be notified about your condition, status and location.
- **FUNDRAISING.** We may use information about you in an effort to raise money for SCHC and its operations. We may disclose health information to a foundation related to SCHC so that the foundation may contact you in raising money for SCHC. We only would release contact information, such as your name, address and phone number and the dates you received treatment or services at SCHC. If you do not want SCHC to contact you for fundraising efforts, you must notify SCHC's ***Compliance Officer*** at: (580) 688-2800 and in writing at: [***Brittani Thibodeaux, 400 E. Sycamore St., Hollis OK 73550***]. Additionally, each fundraising communication will include an opt-out opportunity.
- **HEALTH-RELATED PRODUCTS AND SERVICES.** We may use and disclose health information to tell you about our health-related products or services that may be of interest to you.
- **FAMILY, FRIENDS, OR OTHER INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE.** We may disclose your health information to notify or assist in notifying a family member, your personal representative, or another individual involved in or responsible for your health care about your location at SCHC, your general condition, or in the event of your death. We may also disclose information to someone who helps arrange for payment for your care. If you are able and available to agree or to object, we will give you the opportunity to agree or object prior to making these disclosures, although we may disclose this information in the case of a disaster even over your objection if we believe it is necessary to respond to the disaster or emergency situation. If you are unable or unavailable to agree or object, we will use our best judgment in any communication with your family, personal representative, and other involved individuals.
- **RESEARCH.** Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with patients' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process. However, we may also disclose health information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the health information they review does not leave SCHC.
- **TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. For example, we may notify emergency response personnel about a possible exposure to Acquired Immune Deficiency Syndrome (AIDS) and/or the Human Immunodeficiency Virus (HIV). Any such disclosure, however, would only be to the extent required or permitted by federal, state or local laws and regulations.
- **CHANGE OF OWNERSHIP.** In the event that SCHC is sold or merged with another organization, your health information/medical record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another SCHC, medical group, physician or other healthcare provider.

SPECIAL SITUATIONS

- **FUNERAL DIRECTORS, CORONERS AND MEDICAL EXAMINERS.** We may disclose your health information to funeral directors as necessary to carry out their duties. We may also disclose health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.
- **HEALTH OVERSIGHT ACTIVITIES.** We may disclose your health information to a health oversight agency for activities authorized by federal, state or local laws and regulations. These oversight activities include, for example, audits, inspections, licensure reviews, investigations into illegal conduct, and compliance with other laws and regulations. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **INMATES.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the institution or law enforcement official, if the disclosure is necessary (a) for the institution to provide you with health care; (b) to protect your health and safety or the health and safety of others; or (c) for the safety and security of the correctional institution.
- **LAW ENFORCEMENT.** We may release your health information if asked to do so by a law enforcement official in the following circumstances: (a) in response to a court order, subpoena, warrant, summons or similar process; (b) to identify or locate a suspect fugitive, material witness, or missing person; (c) about the victim of a crime, if, under certain limited circumstances, we are unable to obtain the person's agreement; (d) about a death we believe may be the result of criminal conduct; (e) about

criminal conduct at SCHC; or (f) in emergency situations to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

However, in many situations we are prohibited from sharing, and will not share, your health information for investigations or legal actions concerning reproductive health care access and services where that care is lawful as provided. For example, the law prohibits us from using or disclosing your reproductive health care information in many instances to: (a) respond to investigation requests, court orders, or subpoenas seeking information about or imposing liability on any person for seeking, obtaining, providing, or facilitating lawfully provided reproductive health care; or (b) identify any person that is subject to a criminal, civil, or administrative investigation or legal action, including any in law enforcement investigations, criminal prosecutions, family law proceedings, or state licensure proceedings, for seeking, obtaining, providing, or facilitating lawfully provided reproductive health care.

Some examples of seeking, obtaining, providing, or facilitating reproductive health care include: using reproductive health care; performing, furnishing, or paying for reproductive health care; providing information about reproductive health care; arranging, insuring, administering, providing coverage for, approving, or counseling about reproductive health care; or attempting any of these activities.

- **LAWSUITS AND DISPUTES.** If you are involved in a lawsuit or a dispute, we may disclose your health information to the extent expressly authorized by a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if reasonable efforts have been made to notify you of the request (which may include written notice to you) and you have not objected, or to obtain an order protecting the information requested. In a civil, criminal, administrative, or legislative proceeding against an individual, we will not use or share information about your substance abuse treatment records unless a court order requires us or you give us your written permission.
- **MILITARY AND VETERANS.** If you are a member of the armed forces, we may release health information about you as required by military authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.
- **NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES.** We may release health information about you to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.
- **ORGAN AND TISSUE PROCUREMENT ORGANIZATIONS.** If you are an organ donor, we may disclose health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary, to facilitate organ or tissue donation and transplantation.
- **PROTECTIVE SERVICES FOR THE PRESIDENT AND OTHERS.** We may disclose health information about you to authorize federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or to conduct special investigations.
- **PUBLIC HEALTH REPORTING.** We may disclose health information about you for public health activities. We will only make this disclosure if you agree or when required or authorized by law. These activities generally include the following: (a) to prevent or control disease, injury or disability; (b) to report births and deaths; (c) to report the abuse or neglect of children, elders and dependent adults; (d) to report reactions to medications or problems with products; (e) to notify people of recalls of products they may be using; and (f) to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- **VICTIMS OF ABUSE, NEGLECT OR DOMESTIC VIOLENCE.** We may disclose your health information to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure when required or authorized by law.
- **WORKERS' COMPENSATION**. We may disclose health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **SECURITY CLEARANCES.** We may use medical information about you to make decisions regarding your medical suitability for a security clearance or service abroad. We may also release your medical suitability determination to the officials in the Department of State who need access to that information for these purposes.
- **MULTIDISCIPLINARY PERSONNEL TEAMS.** We may disclose health information to a state or local government agency or a multidisciplinary personnel team relevant to the prevention, identification, management or treatment of an abused child and the child's parents, or elder abuse and neglect.
- **SPECIAL CATEGORIES OF HEALTH INFORMATION.** In some circumstances, your health information may be subject to additional restrictions that may limit or preclude some uses or disclosures described in this Notice or Privacy Practices. For example, there are special restrictions on the use and/or disclosure of certain categories of health information such as: (a) AIDS treatment information and HIV tests results; (b) treatment for mental health conditions and psychotherapy notes; (c) alcohol, drug abuse and chemical dependency treatment information: (d) genetic information; and/or (e) reproductive health care

information, are all subject to special restrictions. In addition, Government health benefit programs, such as Medicare or Medicaid, may also limit the disclosure of patient information for purposes unrelated to the program.

REPRODUCTIVE HEALTH CARE INFORMATION USES AND DISCLOSURES REQURING ATTESTATION

By law, if we collect, receive, or maintain health information that is potentially related to your reproductive health care, in some cases we must obtain an attestation from health information recipients that they will not use or share that information for a purpose prohibited by law. The following situations require attestation:

- **HEALTH OVERSIGHT ACTIVITIES.** We may share your reproductive health care information for health oversight agency audits or inspections, civil or criminal investigations or proceedings, or licensure actions.
- **JUDICIAL AND ADMINISTRATIVE PROCEEDINGS.** We may share your reproductive health care information in response to a court or administrative order, subpoena, or discovery request.
- **LAW ENFORCEMENT PURPOSES.** We may share your reproductive health care information for law enforcement purposes, including in response to a court-ordered warrant or a law enforcement official's request for information about a victim of a crime.
- **CORONERS OR MEDICAL EXAMINERS.** We may share your reproductive health care information in some situations to a coroner or medical examiner to identify a deceased person, determine cause of death, or other duties as authorized by law.

CONFIDENTIALITY OF PSYCHIATRIC OR MENTAL HEALTH RECORDS

The confidentiality of your psychiatric or mental health records maintained by SCHC gets special protection under federal and state laws. We may, however, disclose psychiatric or mental health information that identifies you without your Authorization in the following circumstances:

- **FOR TREATMENT.** We may use your psychiatric/mental health information to provide you with medical treatment or services. We may disclose your psychiatric information to health care professionals outside this facility only if they are responsible for your physical or mental health.
- **FOR PAYMENT.** We may use or disclose your psychiatric/mental health information to substantiate or collect on a claim for mental health treatment or services you receive at SCHC.
- **FOR HEALTH CARE OPERATIONS.** We may use and disclose psychiatric/mental health information about you for our health care operations activities. These uses and disclosures are necessary to operate SCHC efficiently and make sure that all of our patients receive quality care.

ADDITIONAL USES AND DISCLOSURES OF MENTAL HEALTH INFORMATION INCLUDE:

- **DISCLOSURE AT YOUR REQUEST.** We may disclose health information when requested by you. This disclosure at your request may require a written Authorization by you.
- **AS REQUIRED BY LAW.** We will disclose health information about you when required to do so by federal, state or local laws or regulations.
- **FOR LEGAL PROCEEDINGS AND DISPUTES.** If you are involved in a judicial or administrative legal proceeding (lawsuit or a dispute), we may disclose psychiatric/mental health information about you in response to a court or administrative order or when such disclosure is otherwise required or permitted by law. For example, we may disclose psychiatric or mental health information to courts, attorneys and court employees in the course of conservatorship, and certain other judicial or administrative proceedings. We may also disclose mental health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.
- **FOR RESEARCH.** We may disclose your psychiatric/mental health information to researchers who request it for approved medical research projects; however, such disclosures must be cleared through a special approval process before any information is disclosed to the researchers who will be required to safeguard the information they receive.
- **TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. For example, we may notify emergency response personnel about a possible exposure to Acquired Immune Deficiency Syndrome ("AIDS") and/or the Human Immunodeficiency Virus ("HIV"). Any such disclosure, however, would only be to the extent required or permitted by federal, state or local laws and regulations.
- **TO LAW ENFORCEMENT.** We may disclose your psychiatric/mental health information to law enforcement personnel in limited and specific circumstances. For example, we may disclose psychiatric information to law enforcement if your provider determines that there is a probability of imminent physical injury by a patient (to himself/herself or to another person). In the event you post a threat to another person, we will inform the person in danger and disclose the name of the

person you pose a threat/danger to law enforcement as well. In addition, we may disclose your psychiatric/mental health information if a crime has been committed by a patient at SCHC.

- **TO GOVERNMENT AGENCIES.** We may disclose your psychiatric/mental health information to notify the appropriate government agency when required or authorized by law (for example, if we believe that a patient has been the victim of abuse or neglect).
- **TO HEALTHCARE OVERSIGHT AGENCIES.** We may disclose your psychiatric/mental health information to healthcare oversight agencies to ensure that we are meeting the standards of care and services and that we are complying with the applicable laws and regulations. We will only make this disclosure when required or authorized by law.
- **SPECIAL CATEGORIES OF HEALTH INFORMATION.** In some circumstances, your health information may be subject to additional restrictions that may limit or preclude some uses or disclosures described in this Notice or Privacy Practices. For example, there are special restrictions on the use and/or disclosure of certain categories of health information. For example, (1) AIDS treatment information and HIV tests results; (2) treatment for mental health conditions and psychotherapy notes (*see* discussion, below); (3) alcohol, drug abuse and chemical dependency treatment information; and/or (4) genetic information, are all subject to special restrictions. In addition, Government health benefit programs, such as Medicare or Medicaid, may also limit the disclosure of patient information for purposes unrelated to the program.
- **PSYCHOTHERAPY NOTES.** Psychotherapy notes are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record.

Psychotherapy notes include: (a) medication prescription and monitoring; (b) counseling session start and stop times; (c) the modalities and frequencies of treatment furnished; (d) results of clinical tests; and (e) any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.[1] We may use or disclose your psychotherapy notes, for treatment, payment or healthcare operations, or:

1. for use by the originator of the notes;
2. in supervised mental health training programs for students, trainees, or practitioners;
3. by the Covered Entity to defend a legal action or other proceeding brought by the individual;
4. to prevent or lessen a serious and imminent threat to the health or safety of a person or the public;
5. for the health oversight of the originator of the psychotherapy note;
6. for use or disclosure to coroner or medical examiner to report a patient's death, and information related to the diagnosis and treatment of the patient's physical condition;
7. for use or disclosure necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public;
8. for use or disclosure to the Secretary of the U.S. Department of Health and Human Services ("HHS") in the course of an investigation; and/or
9. as required by law.

Generally, we will not tell anyone outside SCHC that you are being treated by SCHC for a psychiatric or mental health issue.

Other uses and disclosures of your psychiatric or mental health information not covered by this Notice of Privacy Practices, Psychiatric Addendum or the laws that apply to us will be made only with your written Authorization.

Please see the general Notice of Privacy Practices for information on revoking an Authorization for the Use or Disclosure of Health Information. Your rights regarding your health information outlined in the general Notice of Privacy Practices also apply to your psychiatric/ mental health information.

EXCEPTIONS FOR MORE RESTRICTIVE LAWS

- **SUBSTANCE USE DISORDER INFORMATION FROM PART 2 PROGRAM.** If we receive or maintain any information or record about you from a substance use disorder ("SUD") treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") and you have consented to us receiving this information for treatment, payment, and health care operation activities, then we may further disclosure your SUD Part 2 Program information in accordance with HIPAA (except as provided in the two paragraphs immediately below). In no event will we use or disclose your SUD Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order. We will not use or disclose your Part 2 Program record for our fundraising purposes without first giving you a clear and conspicuous opportunity to elect not to receive any fundraising communications.

[1] 45 C.F.R. § 164.501.

YOUR PRIVACY RIGHTS

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

- **RIGHT TO INSPECT AND COPY.** You have the right to inspect and copy health information that may be used to make decisions about your care. Usually this includes medical and billing records, but may not include some mental health information. If you request a copy of your health information that may be used to make decisions about your care, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to:

  Shortgrass Community Health Center
  400 E. Sycamore St.
  Hollis, OK 73550
  Attention:_Brittani Thibodeaux or Ginger Creech

  We may deny your request to inspect and copy in specific circumstances. If you are denied access to your health information, you may request that the denial be reviewed. Another licensed health care professional chosen by SCHC will review your request and the denial. The person conducting the review will not be the person who denied your request. SCHC will comply with the outcome of the review.
- **RIGHT TO REQUEST RESTRICTIONS.** You have the right to request a restriction or limitation on the health information SCHC uses or discloses about you for treatment, payment or health care operations. You can also request a restriction or limitation on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

- **WE RESERVE THE RIGHT TO ACCEPT OR REJECT YOUR REQUEST**. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. We will notify you if we do not agree to a requested restriction. To request restrictions, you must submit a written request to SCHC at the above address. In your request, you must state: (a) what information you want to limit; (b) whether you want to limit its use, disclosure or both; and (c) to whom you want the limits to apply; for example, no disclosures to your spouse.

- **RIGHT TO RESTRICT DISCLOSURE FOR SERVICES PAID BY YOU IN FULL.** You have the right to restrict the disclosure of your health information to a health plan if the health information pertains to health care services for which you paid in full directly to SCHC and the disclosure is not otherwise required by law.

- **RIGHT TO AMEND.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment to your health information for as long as the information is kept by or for SCHC. You must make your request to amend your health information, in writing, and submit it to SCHC at the above address. You must include a reason that supports your request. In addition, we may deny your request if you ask us to amend information that:

  1. Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  2. Is not part of the health information kept by or for SCHC;
  3. Is not part or the information which you would be permitted to inspect and copy; or
  4. Is accurate and complete.

  The law permits us to deny your request for an amendment if it is not in writing or does not include a reason to support the request.
  Even if SCHC denies your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your medical record we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.
- **REQUEST AN ACCOUNTING OF DISCLOSURES.** You have the right to request an "accounting of disclosures." Such an accounting is a list of the disclosures we made of health information about you other than our own uses for treatment, payment and health care operations (as those functions are described above) and with other expectations pursuant to law. To request this list or accounting of disclosures, you must submit your request in writing to SCHC at the above address. Your request must state a time period that may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS.** You have the right to request that we communicate with you about health 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. You must make your request for confidential communications in writing to SCHC at the address noted above. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE.** You have the right to receive a paper copy of this Notice. You may request a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.
- **RIGHT TO NOTICE OF BREACH.** You have the right to be notified if we or one of our Business Associates becomes aware of an improper disclosure of your health information.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time. We reserve the right to make the revised or changed Notice effective for all health information we have about you as well as any information we receive in the future. We will post a copy of the current Notice in SCHC. The Notice will contain the effective date on the first page, in the top right-hand corner. If we amend this Notice, we will offer you a copy of the current Notice in effect. You may request a copy of the current Notice each time that you visit SCHC for services or by calling SCHC and requesting that the current Notice be sent to you in the mail.

FOR MORE INFORMATION, TO FILE A COMPLAINT OR TO REPORT A PROBLEM

If you believe that your privacy rights have been violated, please let us know promptly so we can address the situation. You may file a complaint with SCHC and/or with the Secretary of the federal Department of Health and Human Services. All complaints must be submitted in writing.
To file a complaint with SCHC, send a written complaint to SCHC's Privacy Officer at:

Shortgrass Community Health Center
400 E. Sycamore St.
Hollis, OK 73550
Attention: Brittani Thibodeaux

If you would like to discuss a problem without submitting a formal complaint, you may contact the Privacy Officer by telephone at (580) 688-2800; or by facsimile at (580) 688-2193; or via e-mail at: bthibodeaux@shortgrasschc.com. In addition, you may contact the Executive Director by telephone at (580) 688-2800; or by facsimile at (580) 688-2193; or via e-mail at: gcreechhortgrass.com.

You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will stop the uses and disclosures allowed by that permission, except to the extent that we have already acted in reliance on your permission. For example, we are unable to take back any disclosures we have already made with your permission.

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 of communication with our Health Team.
- The patient/parent is honest in the history of symptoms. Your Health Team is open and honest in relating the diagnosis 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 understandable instructions.
- 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 will respect 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 but instructions 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 our providers.
- 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 specifiedpharmacy electronically, otherwise, a printed prescription will be provided.
- This agreement that describes your SCHC Health Care Team relationship with YOU has been given to andreceived by a patient/parent for his or her Health Team member today.

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.

Shortgrass
COMMUNITY HEALTH CENTER, INC.

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: ☐

Revised 8/26/2024

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.

______ Locations

______ Cancellation & No-Show Policy

______ 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 (if signed by representative)

____

Representative's Relationship to Patient

Shortgrass
COMMUNITY HEALTH CENTER, INC.

INFORMED CONSENT FOR TELEMEDICINE SERVICES

Telemedicine involves the use of electronic communications to enable health care providers at different locations to assist in the evaluation, diagnosis, management and treatment of a number of health care problems. Providers may include primary care practitioners, specialists, and/or sub-specialists.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

By signing this form, I understand the following:

1. The consulting health care provider or specialist will be at a different location from me. A health care provider or other health care professional may be present with me in the room to assist in the consultation.
2. The presenting health care provider or professional health care staff may transmit or share electronically details of my medical history, examinations, x-rays, tests, photographs or other images with the provider who is at a different location.
3. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
4. I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas.
6. A record of the consultation will be kept in my medical record.
7. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.
8. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

☐ I have read and understand the information provided above regarding telemedicine. I hereby give my informed consent for the use of telemedicine in my health care.

☐ I do not consent to the use of telemedicine in my health care.

______________________________ ______________

Patient or Patient's Representative Signature | Date

______________________________ ______________

Please Print Your Name | Patient's Name (if signed by representative)

____

Representative's Relationship to Patient

400 E. Sycamore • P.O. Box 311 • Hollis, OK 73550
Phone: (580) 688-3314 • Fax: (479) 688-2193

Client Name: ______________________ Date of Birth: ______________

Shortgrass Community Health Center

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

☐ **Receiving** ☐ **Disclosing** ☐ **Receiving** ☐ **Disclosing**

Name, Title	**Name, Title**
Site Address	**Site Address**
Phone	**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

New Patient Registration Form

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: ☐Elem. ☐ 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: ____________________________

Shortgrass COMMUNITY HEALTH CENTER, INC.

Child Psychiatric Intake Form

NAME:		DATE:
DATE OF BIRTH:	AGE:	GENDER:
PRIMARY CARE PHYSICIAN:		PHONE:
CURRENT THERAPIST/COUNSELOR		PHONE
WHO REFERRED YOU TO THIS PRACTICE		PHONE
Name:		

MOTHER'S NAME	AGE	FATHER'S NAME	AGE
Address:		Address:	
Phone:		Phone:	

Marital Status of Parents:	Married ☐	Divorced ☐	Blended ☐	Separated ☐	Widowed ☐

Who legal custody?		Type:
Who has physical custody?		Type:

Please describe the presenting problem:
What concerns you most about your child?
When did you first notice this problem?
How has this problem Affected his/her function?

At home:	
At school/work:	
Community:	

Continued on next page:

Please complete all information. The information on this form is strictly confidential.

Do you have other concerns that you would like addressed?

Symptom Checklist

Please check the symptoms below that your child has been experiencing over the past few weeks which cause you to worry.

Yes	No	Symptom
☐	☐	**Depression:** sad, irritable, hopeless, helpless, difficulty sleeping, crying, sleeping too much, decreased energy/fatigue, feelings of worthlessness or guilt, difficulty thinking or concentrating, difficulty making decisions, social withdrawal/isolative behaviors, lack of interest in things, suicidal thoughts, etc.
☐	☐	**Mood Swings:** energetic, little sleep, pleasure seeking, racing thoughts, too talkative, inappropriate sexual behaviors, grandiose, etc.
☐	☐	**Anxiety:** worries, restless, scared, poor sleep, obsessive thoughts and/or compulsive behaviors, frequent complaining of headaches and/or stomach aches, frequent school absences, etc.
☐	☐	**Behavioral Problem:** fights/physical aggression, anger, arguing, truancy, destruction of property, fire setting, etc.
☐	☐	**Attention/Hyperactivity Problem:** difficulty paying attention, easily distracted, difficulty completing tasks, hyperactive, impulsive, etc.
☐	☐	**Abnormal Eating Behaviors:** too much/significant weight gain, too little/significant weight loss, fear of weight gain, distorted body image, excessive exercising, etc.
☐	☐	**Social Anxiety:** shy and/or afraid to be around others, avoidance of crowds, avoidance of public places, etc.
☐	☐	**Remembering Past Traumas:** frequent nightmares, intrusive and/or recurrent memories, etc.
☐	☐	**Autism:** social and language impairments, rigidity, etc.
☐	☐	**Psychosis:** hearing voices, seeing things, paranoia, delusions, etc.
☐	☐	**Dissociation:** feeling outside your body or things are not real, etc.
☐	☐	Has your child ever harmed themselves intentionally?
☐	☐	Has your child ever attempted suicide?
☐	☐	Has your child ever harmed others? (including harm to animals)
If yes, please explain:		

Please list all CURRENT psychiatric medications.				
Medication Name:	**Dose(s)**	**Date(s)**	**Response(s) & Side-effects**	**Provider/Facility**

Past Psychiatric History

Please list all PAST psychiatric medications.				

Please answer the questions below.	**Yes**	**No**
Has your child ever been admitted to a psychiatric hospital (this includes residential or day treatment programs, including any alcohol and drug treatment programs)? *(If yes, please list below.)*	☐	☐

Date: *Month/Year*	Diagnosis:	Length of Stay:	Facility/Location:

Has your child ever received mental health or substance use disorder (alcohol/drug) treatment as an outpatient (counseling or medication)? *(If yes, please list below.)*	☐	☐

Date:	Provider:	Reason:
Date:	Provider:	Reason:
Date:	Provider:	Reason:

Family History

Has anyone in your family been diagnosed or treated for: ***(Please list family member, mother, father, etc)***							
Diagnoses	**Yes**	**No**	**Family Member**	**Diagnoses**	**Yes**	**No**	**Family Member**
Depression	☐	☐		Suicide Attempts	☐	☐	
Anxiety	☐	☐		Completed Suicide	☐	☐	
ADHD	☐	☐		Panic Disorder	☐	☐	
Bipolar	☐	☐		PTSD	☐	☐	
Schizophrenia	☐	☐		OCD	☐	☐	
Alcohol Problems	☐	☐		Seizures	☐	☐	
Drug Problems	☐	☐		Migraines	☐	☐	
Learning Disabilities	☐	☐		Heart Problems	☐	☐	
Autism	☐	☐		Lung Problems	☐	☐	
Asperger’s	☐	☐		Thyroid	☐	☐	
PDD	☐	☐		Immune Disorders	☐	☐	
Mental Retardation	☐	☐		Cancer	☐	☐	
Nervous Breakdown	☐	☐		Other	☐	☐	

Are there any other family medical problems that run in your family?			☐	☐	
If yes, what disease and who did/does it effect? (*Please list disease and family member.*)					
Disease	Family Member	Disease			Family Member
1.		5.			
2.		6.			
3.		7.			
4.		8.			
Has any family member been admitted to a psychiatric hospital? *If yes,*			☐	☐	*Please list below.*

Date: *Month/Year*	Diagnosis	Family Member	Facility/Location
If known, what medications were used in treatment?			

Childs Medical History

Please list any drug allergies and describe the reaction that your child had:	
Drug Name	Reaction

Has your child ever had:	**Yes**	**No**		**Yes**	**No**
Loss of Consciousness	☐	☐	Heart Problems	☐	☐
Head Injury	☐	☐	Heart murmur	☐	☐
Seizures	☐	☐	Stroke	☐	☐
High blood pressure	☐	☐	Thyroid problems	☐	☐
Diabetes	☐	☐	Stomach Ulcer	☐	☐
Arthritis	☐	☐	GERD (acid reflux)	☐	☐
Back or neck Pain	☐	☐	Liver disease	☐	☐
Asthma	☐	☐	Kidney Problems	☐	☐
COPD	☐	☐	Menstrual Problems	☐	☐
Eczema	☐	☐	Cancer	☐	☐
If yes for cancers, what type and describe any required treatment?					

Any other medical problems not listed above? If so, please list here:

Please list ALL **surgeries**:	List **Non-Psychiatric hospitalizations**:
1.	1.
2.	2.
3.	3.

List ALL **non – psychiatric** medications & doses that your child is ***currently*** taking, including supplements, vitamins and over the counter medications.

Name	Dosage	Duration	Response

Developmental History:

At what age did your child achieve the following milestones?

Age	Milestone
	Language (age at first using words, sentences, etc.)
	Fine Motor Skills (building towers with cubes, drawing circles, etc.)
	Gross Motor Skills (rolling over, standing, walking, etc.)
	Toilet Training

Has your child experienced any regression of these skills? If yes, explain:	Yes	No
	☐	☐
Does your adolescent have a job?	☐	☐
Is your child sexually active?	☐	☐
Are you concerned about your child's sexual activities?	☐	☐
Does your child have quality relationships with other children? *If no, please explain:*	☐	☐
Has your adolescent had a recent change in friendships? *If yes, what changes concern you?*	☐	☐
Do you have any concerns regarding your child's friendships? *If yes, please explain:*	☐	☐

Too Old	☐	Too Young	☐	Truant	☐	Gang Fringe	☐
Drug	☐	Alcohol	☐	Violence	☐	Too Many	☐
Too Few	☐	Sexual Promiscuity	☐	Too much time	☐	Other	☐

If other, please list concern:	

Substance Use

Please indicate any substances used currently or in the past by your child:			
Substance	**Yes**	**No**	**If yes, how long, frequency, last use and age?**
Tobacco	☐	☐	
Vapes	☐	☐	
Alcohol	☐	☐	
Marijuana	☐	☐	
Cocaine/Crack	☐	☐	
Ecstasy	☐	☐	
Huffing (gas, aerosol)	☐	☐	
Prescription Drug Abuse	☐	☐	
Bath Salts	☐	☐	
Methamphetamine	☐	☐	

School

Where does your child attend school?			
In what grade level is he/she?			
What are his/her typical grades?			
What are your child's academic strengths?			
Academic weaknesses?			
Has there been a change in your child's performance at school? *If yes, please describe:*		**Yes**	**No**
Describe		☐	☐
Has your child received IQ or Academic Testing? *If yes, what were the results?*		☐	☐
Results			

Please complete all information. The information on this form is strictly confidential.

Receive any resource/assistance? (for which classes/how many hours?)						☐	☐
Class		Hours		Class		Hours	
Class		Hours		Class		Hours	
Class		Hours		Class		Hours	
Participate in accelerated or honors programs? *If yes, please explain below:*						☐	☐
Is on a 504 plan? *Please explain below:*						☐	☐
Is on an Individual Education Plan (IEP)? *Please explain below:*						☐	☐

Has your child had problems with any of the following? *If yes to any, please explain.*					
Problem	Yes	No	Problem	Yes	No
Truancy	☐	☐	Detention	☐	☐
Fights	☐	☐	Suspension	☐	☐
Absenteeism	☐	☐	School refusal	☐	☐
Explain:					

Social History

Is your child your biological child? *If not, please explain:*		Yes	No
Describe		☐	☐
If your child was adopted, at what age was he/she adopted?	Age		
Is there any contact with their biological parents?		☐	☐
Where was your child born and raised?			
Do you have a religious preference in the household? *If yes, what is that preference?*		**Yes**	**No**
Religious Preference		☐	☐
Has your child experienced any problems related to race, religion, or culture? *If yes, explain:*		**Yes**	**No**
Explain:		☐	☐

Please list all relevant family members related to the child (*step-parents, siblings, step, grand, etc.)*:					
Family Member	**Relationship**	**Lives at home**	**Family Member**	**Relationship**	**Lives at home**
		☐			☒
		☐			☐
		☐			☐
		☐			☐
		☐			☐
		☐			☐

Is there anything else we should know about you?

Abuse History

Has your child ever been the victim of abuse or neglect? *If yes, what was the nature of the abuse?*	Yes	No
	☐	☐

Has your child ever been involved with the following and, if yes, please explain:			
Service	**Yes**	**No**	**If yes, please explain:**
Child Protective Services	☐	☐	
Law Enforcement	☐	☐	
Detention Involvement	☐	☐	
Court Involvement	☐	☐	
Probation	☐	☐	
Juvenile Probation	☐	☐	
Detention	☐	☐	
Early Intervention Service (ages 0-3)	☐	☐	
Head Start:	☐	☐	

Emergency Contact ________________________________ Relationship ________________

Phone Number ____

By signing below, I certify all information is true and correct to the best of my knowledge and I consent to treatment for my minor child.

Signature ____

Date_____________________________

Please complete all information. The information on this form is strictly confidential.