COMMUNITY MEDICAL CLINIC

NEW PATIENT PACKET

1102 S Virginia Street - Hopkinsville, KY 42240 - 270-632-6741 - 270-632-6742 (Fax)
Dental 1102 S Virginia Street Suite B - Hopkinsville, KY 42240 - 270-632-3088 - 270-632-8212 (Fax)
244 Thompsonville Lane - Oak Grove, KY 42262 - 270-632-6743 - 270-632-6744 (Fax)
1022 W Main Street - P.O. Box 151 - Princeton, KY 42445 - 270-365-0227 - 270-365-2559 (Fax)

In order to help the check in process, please fill in ALL information.

PART A

I. Patient Information

_____, _____, _____
Last Name ***First Name*** ***Middle Name***

What name would you like to go by? _____

Address:_____ **Zip Code**: _____
Home Phone: (___)_____ **Cellular:** (___)_____**Work**: (____)_____
Email Address:_____ **Preferred Communication:** ☐ Phone ☐ Text ☐ Email
Preferred Phone Contact: ☐ Home ☐ Cell ☐ Work

Circle Gender at Birth: M / F **SSN:** _____ - _____ -_____ **Date of Birth:** _____
Gender Identification (please choose one): ☐ Male ☐ Female ☐ Transgender- male-to-female
☐ Transgender-female to male ☐ Non Binary
Sexual Orientation (please choose one): ☐ Lesbian or Gay ☐ Straight or Heterosexual ☐ Bisexual
☐ Something Else ☐ Don't Know ☐ Choose Not To Disclose

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widow / Widowed ☐ Unknown

Education: (choose the highest education level completed)
☐ None ☐ 1-6 grade ☐ 7-8 grades ☐ some high school ☐ GED ☐ High school diploma ☐ Associates Degree
☐ Bachelors' degree ☐ Masters' degree or higher ☐ Some College

Race: ☐ Native American/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ White
☐ Middle Eastern/North African ☐ Other

Ethnicity: ☐ Hispanic / Latino ☐ Non-Hispanic / Non-Latino
Other:_____

Preferred Language: ☐ English ☐ Spanish ☐ Other_____
☐ Interpreter Needed?

We offer interpreter services through AMN Healthcare language services

Living Situation: ☐ Homeless ☐ Not Homeless ☐ Transitional ☐ Doubling Up ☐ Street ☐ Other ☐ Unknown

Agricultural Worker: ☐ Migrant ☐ Seasonal ☐ Not an Agricultural Worker

Are you a U.S. Veteran? ☐ Yes ☐ No

IN CASE OF EMERGENCY

Please contact (name):_____ **Phone(s):**_____

Address:_____ **Relation:**_____

Preferred Pharmacy:_____ **Phone:**_____

INSURANCE INFORMATION

Complete this section only if your insurance card is not present

Primary Insurance: _____ **ID#**_____ **Group#**_____

Subscriber's Name:_____ **DOB:**_____ **Phone#**_____

Secondary Insurance:_____ **ID#**_____ **Group#**_____

Subscriber's Name:_____ **DOB:**_____ **Phone#**_____

Subscriber Address (if different than the patient): _____

_____

II. RESPONSIBLE PARTY INFORMATION

Employment: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Full-Time Student ☐ Retired ☐ Active Military ☐ Unknown

Responsible Party Name: _____ **Employer Name:**_____

Employer Address: _____ **Employer Phone:**_____

VI. Required Information and Acknowledgements

Release of Medical Records

In the event of a referral to a specialist or outside medical provider, I authorize Community Medical Clinic to release my medical records for continuity of care. This release excludes behavioral health records, HIV/AIDS status, and substance abuse information unless I complete a separate consent form. Community Medical Clinic will refer me to my preferred qualified provider; if unavailable, they will find similar specialists. This authorization remains valid until I revoke it in writing.

Patient Signature:_____ **Date**:_____

Patient's Legal Representative's Signature (if needed) _____ **Date:**_____

CONSENT for TREATMENT

By seeking care at Community Medical Clinic, I consent to necessary examinations and treatments. I understand that medicine is not exact and that there are risks involved, including injury or death, and acknowledge that no guarantees have been made regarding the outcomes of my care.

Patient / Representative Signature:_____ **Date:**_____

V. HOUSEHOLD INCOME INFORMATION

Note: ***As a Federally Qualified Health Center (FQHC), we provide Sliding Fee Scales which may help you with your health care expenses. To help us determine if you may qualify, please answer below.*** **This information is only used to obtain the grants we use to help those who do not have insurance and will not affect you in any adverse way.**

What is your annual household income?_____ How many people are in your household?_____

☐ No Income ☐ Less than 24,999 ☐ 25, 000 to 39,999 ☐ 40,000 to 59,999 ☐ 60,000 to 99,999

☐ 100,000 or more

If you are interested to know more about our Sliding Fee Scale Program, please fill out the enclosed Sliding Fee Scale discount program section below.

A sliding scale **discount program is available for our uninsured and under-insured patients who may have difficulty paying.**

Pennyroyal Healthcare Services, Inc.

2025 Sliding Fee Schedule Medical and Behavioral Health
(Based on 2025 DHHS Federal Poverty Guidelines)
Effective February 2025

Poverty Level	Class A FPI 100% or below	Class B FPI 101%-125%	Class C FPI 126%-150%	Class D FPI 151%-200	Class E FPI > 200%
	Discount				
Family Size	$20	75%	50%	25%	0%
1	$15,650	$19,563	$23,475	$31,300	$ 30,121
2	$21,150	$26,438	$31,725	$42,300	$ 40,881
3	$26,650	$33,313	$39,975	$53,300	$ 51,641
4	$32,150	$40,188	$48,225	$64,300	$ 62,401
5	$37,650	$47,063	$56,475	$75,300	$ 73,161
6	$43,150	$53,938	$64,725	$86,300	$ 83,921
7	$48,650	$60,813	$72,975	$97,300	$ 94,681
8	$54,150	$67,688	$81,225	$108,300	$ 105,441
For each additional person, add	$6,330				

□ Yes, I am interested in information regarding the sliding scale program.

□ No, I am not interested at this time in the sliding scale program and I do not wish to disclose my income.

Signature: _____

Date: _____

Once the paper is signed, please return it to the receptionist.

Pennyroyal Healthcare Services, Inc DBA Community Medical Clinic

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I. My Authorization

I authorize the following person(s) to receive my health information:(i.e spouse, parent, child or etc)

_____

To use or disclose the following health information: (check one)

☐ - All of my health information

☐ - My health information relating to the following treatment or condition:

_____

☐ - My health information covering the period from _____ (date) to _____ (date)

☐ - Other: _____

Signature of Patient or Authorized Representative: _____

Date: _____ Time: _____

II. Additional Consent for HIV/AIDS

This medical record may contain information concerning **HIV Testing and/or AIDS diagnosis or treatment.** Separate consent must be given to have this information released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released

Signature of Patient or Authorized Representative: _____

Date: _____ Time: _____

III. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing part. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.
I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____

If the patient is a minor or unable to sign, please complete the following:

☐ Patient is a minor: _____ years of age

Signature of Authorized Representative _____ Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient: _____

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____

VI. Required Information and Acknowledgements

Release of Medical Records

In the event that my physician / provider recommends (and I agree to) referral to a specialist, an outside Health Care Center, or other outside medical provider, I hereby authorize Community Medical Clinic to release my medical records as required to the indicated specialty physician, provider and/or the referral health center for the purpose of continuity of care.

I understand that this release does not apply to my behavioral health records, HIV/AIDS status, nor substance (drug, alcohol, etc.) abuse information, if it exists. If there is need for the release of behavioral health records, substance abuse history, or HIV/AIDS status, I will be notified. I will need to complete another Release of Information form specifically granting my consent for such release, if I agree to the records transfer.

I also understand that if I am being referred to a specialist physician or provider, or to a specialty health center, Community Medical Clinic will make the referral to the qualified entity of the patient's choice. If the patient's preferred entity refuses the referral, can't see the patient in a timely manner, or is unavailable, the Community Medical Clinic referral team will seek 'likes specialists' (i.e. physicians, providers, or specialty health centers) to provide care for the patient.

I understand that this release of my medical information is required to facilitate a referral (which is made by my Community Medical Clinic provider and accepted by me) stays in force unless I revoke it in writing to Community Medical Clinic.

Patient Signature:_____ **Date**:_____

Patient's Legal Representative's Signature (if needed)_____ **Date:**_____

CONSENT for TREATMENT

In seeking medical care from Community Medical Clinic, I do hereby voluntarily consent to such examination and treatment as is deemed necessary by Community Medical Clinic. I understand the practice of medicine is not an exact science, and that diagnosis and treatment involve risks of injury or even death. I acknowledge that Community Medical Clinic providers have made no guarantees to me as a result of examination or treatment.

Patient / Representative Signature:_____ **Date:**_____

Do you have an Advance Directive? ☐ **yes** ☐ **no**

If no, would you like some information about Advance Directives? ☐ **yes** ☐ **no**

Patient Acknowledgement:

Cancellation of Appointments. I agree to schedule appointments for my treatment. I agree that I will call and cancel my appointment at least 24 hours prior to the appointment time, if cancellation is necessary. I understand that if I have three missed or cancelled appointments, I may be discharged from the Health Center practice.

No Call / No Show. I understand that missing 3 appointments within 12 months as a no call/no show **may** cause me to be discharged from the practice.

I understand that if I have any problems getting to my appointment, I can let Community Medical Clinic know in advance and they may be able to **help me with transportation**.

Notice of Privacy Practices. I have received a copy of the Notice of Privacy Practices.

Responsibility for Payment. For and in consideration of services rendered, or to be rendered, to the named patient, I or we, or either of us do hereby promise to pay Community Medical Clinic the full amount of all charges incurred. I/we understand that Community Medical Clinic will file commercial insurance as a courtesy. Community Medical Clinic will allow 30 days for the insurance to resolve the outstanding charges.

Patient / Representative Signature:_____ Date:_____

Co-Signature (if needed)_____ Date:_____

END PART A

Please continue to the next section, PART B.

Part B

Medical History Form

Name:	Male ☐ Female ☐	DOB:
Previous Doctor:	Date of last physical Exam:	

Any Specialists You See:	Reason you see this Specialist

Medical Conditions you have been diagnosed with in the past:
Allergies to Medications or Substances:

Surgeries	Date/Hospital
Colonoscopy? Yes ☐ No ☐	Date of Most recent Colonoscopy:

Other Hospitalizations	Date/Hospital

List All Prescribed and Over the Counter Medications you take including vitamins and inhalers

Name of Drug	Strength	Frequency taken

Personal Habits/Social History		
Do you drink alcohol?	YES_____	NO_____
-If yes, how may drinks per week?		
- Are you concerned about the amount you drink?	Yes_____	No_____
- Have you considered stopping drinking?	YES_____	NO_____
Do you use tobacco?	Yes_____	No_____

Cigarettes ☐ #per day_____	Smokeless Tobacco ☐	Pipe ☐
Number of years smoked_____	Ready to Quit ( )	
Former Smoker Yes ◯ No ◯	Year Quit _____	

Do you currently use any recreational/street drugs?	Yes ◯ No ◯
Have you ever injected street drugs with a needle?	Yes ◯ No ◯
Are you sexually active?	Yes ◯ No ◯
Any concerns for STD or diseases such as HIV/AIDs?	Yes ◯ No ◯
Safety Concerns:	Yes ◯ No ◯
Do you live alone?	Yes ◯ No ◯
Do you have frequent Falls?	Yes ◯ No ◯
Do you have vision or hearing loss?	Yes ◯ No ◯
Do yo uhave an Advance Directive or Living Will?	Yes ◯ No ◯
Has anyone hit your or hurt you physically in the past ?	Yes ◯ No ◯
Has anyone verbally abused you?	Yes ◯ No ◯
Do you feel safe?	Yes ◯ No ◯

Immunizations:

Influenza vaccine Y ◯ N ◯ Date:	Pneumonia Vaccine Y ◯ N ◯ Date:
Tetanus/TDAP Y ◯ N ◯ Date:	Shingles Vaccine Y ◯ N ◯ Date:

Self and Family Medical History

List any Significant health problems such as diabetes, heart disease, stroke, COPD, Mental illness, Hypertension, cancer that your family members have had

Father:	Alive ◯ Deceased ◯
Mother:	Alive ◯ Deceased ◯
Children:	Alive ◯ Deceased ◯
Siblings:	Alive ◯ Deceased ◯
Maternal Grandmother:	Alive ◯ Deceased ◯
Maternal Grandfather:	Alive ◯ Deceased ◯
Paternal Grandmother:	Alive ◯ Deceased ◯
Paternal Grandfather:	Alive ◯ Deceased ◯

Women's Health- only applies to female patients

Are you pregnant or breastfeeding? Yes ◯ No ◯
Number of Pregnancies_____ Number of live births_____
Date of last menstrual period:_____
Date of last pap?_____
Date of last mammogram_____

PART C

Community Medical Clinic

Better Health Through Professional Care

Pennyroyal Healthcare Services, Inc
1102 S Virginia Street - Hopkinsville, KY 42240 - 270-632-6741 - 270-632-6742 (Fax)
244 Thompsonville Lane - Oak Grove, KY 42262 - 270-632-6743 - 270-632-6744 (Fax)
310 Hawthorne St. - P.O. Box 151 - Princeton, KY 42445 - 270-365-0227 - 270-365-2559 (Fax)

Patient Rights & Responsibilities

Our Patients / Clients Have a Right to:

- **SERVICE:** Service regardless of your race, sex, religion, age, ethnic background, linguistic preference, education, social class, economic status, or disability.
- **RESPECT AND FREEDOM FROM ABUSE:** Expect that our staff will be sensitive to your needs and feelings, and to be treated with respect and dignity.
- **PRIVACY:** Consideration for your privacy. Treatment is confidential and should in all cases be conducted discreetly.
- **INFORMATION:** Know your diagnosis, treatment plan, prognosis, and probable consequences of treatment, as well as possible consequences if treatment is not given. To know any other significant information that would enable you to give informed consent.
- **CHOICE:** Be involved in the planning the medical services that you are to receive, and to consent to or refuse treatment.
- **CONFIDENTIALITY:** Confidentiality in personal matters, interpersonal relations, and written healthcare records, along with access to those written records.
- **CONTINUITY OF CARE:** Referral to other services, specialties, and agencies that are necessary for your health and continuity of care.
- **REVIEW THEIR MEDICAL RECORDS** and,
- **BILLING:** Obtain, question, review, and discuss a full accounting of charges for your medical or behavioral care regardless of the source of payment.
- **RECOMMENDATIONS:** Make constructive recommendations for improvement of policy, communications, or service changes that will affect you as a healthcare consumer.
- **KNOWLEDGE OF EXPECTATIONS:** Know the rules and standards that apply to your conduct as a patient/client.
- **COMMUNICATION:** Have all communication in a language that you clearly understand. If needed, you may have interpretive services.
- **GRIEVANCES:** File a complaint about service-related issues or the treatment being provided, and to request assistance in the filing of a complaint.
- **SUGGESTIONS AND COMPLIMENTS:** Participate in the patient satisfaction survey each time you visit us. You may call (270-365-0227) if you would like to discuss an issue or complaint you may have regarding your experience with Community Medical Clinic. As well, you can use this same line to give a compliment regarding any excellence of service you experienced at Community Medical Clinic. If you prefer, a staff member will help you reach a manager.

Our Patients / Clients Have the Responsibility To:

- Arrive on time for appointments.
- Provide at least twenty-four (24) hours' notice of appointment cancellation.
- Participate in the development of mutually agreed upon treatment plans and follow such plans.
- Ask questions about specific problems or request information when they do not understand their illness, diagnosis, medications, or treatment.
- Provide accurate and complete medical information to healthcare providers / physicians.
- Show respect and consideration of other patients, staff, Community Medical Clinic property, and property of other patients or visitors.
- Tell us if one of our team members gave you excellent service.
- Let us know if you are dissatisfied with our service.
- Comply with signed patient contracts.
- Follow all insurance company guidelines about how to access services.
- Take financial responsibility for payment of all charges including:

    - To bring your insurance card, if you are insured, each time you come to Community Medical Clinic for services.
    - To pay all co-payments and deductibles at the time of your visit, if you are insured.
    - To pay at the time of your visit for services rendered if you are uninsured.
    - To bring in documentation of eligibility for discount in a timely manner, if you are uninsured.
    - To bring in documentation of eligibility for Medicaid in a timely manner, if requested by Community Medical Clinic.
    - To contact the billing department immediately to make payment arrangements if you cannot pay.

Notice of Privacy Practices

Community Medical Clinic values the privacy of your health information. This Notice of Privacy Practices describes examples of how we may use and give out ("disclose") your personal health information. This is not a complete list.

Our duties. We are required by law to protect the privacy of your health information. We are also required to give you this notice to tell you how we may disclose your personal health information. We are required to abide by the terms of this Notice. We may change the terms of our notice at any time. Any new notice will be effective for all personal health information that we maintain at that time.

What type of personal health information may we collect? The personal health information that we collect may include your name, address, birth date, social security number, medical and mental health history, payment sources, the names of your care givers (doctors, etc.) and how to contact your family and others involved in your care.

When we may use or give out your personal health information without your authorization? The following categories describe such Health Information disclosures.

1. **Treatment, payment, and health care operations.** The following are examples of how we may disclose your personal health information to deliver treatment, obtain payment, and operate our programs and business:
   a. We may share information with other health care providers who are involved in your care such as physicians, outside consultants and other facilities to which you may be transferred.
   b. We may share information with our business associates who perform services for us (e.g. billing, audit services). If we do share information with them, we will have a written contract that will obligate the business associate to protect the privacy of your personal health information.
   c. We may disclose your information to obtain payment. This may include sharing information with your health insurance as it makes payment decisions. They may verify your coverage and review services for medical necessity. We may also disclose your information to another health care provider to help them obtain payment.
   d. We may disclose your information to operate our programs and business. For example, we may use your information for our quality and safety programs. We may also use it to train medical students.
   e. We may contact you about your appointment.
   f. We may call you by name in the waiting room.
   g. We may contact you for a donation.
   h. We may contact you about treatment options, other health-related benefits, and other products and services that we offer.
   i. We may share your information with manufacturer representatives. For example, a technical advisor on new devices may be present during surgery to answer questions from the operating team.
   j. We may collect data for analysis. In many cases, we will take out information that might identify you personally. In other cases, we will use only limited information as permitted by the privacy laws for research, public health purposes, or health care operations.
2. **Required By Law**. We may use or disclose your personal health information as required by law. The use or disclosure will be made in strict compliance with the law.
3. **Public Health.** We may give out your personal health information for public health purposes. For example: We report limited information to a public health authority in order to prevent or control disease, injury, or disability.

For example, we contact the Health Department when we identify certain diseases, such as tuberculosis. We may give your personal information to the Food and Drug Administration (FDA) about a product or activity that relates to your health.

4. **Contagious Diseases.** When permitted by law, we may disclose your information to a person who may have been exposed to a communicable disease.
5. **Health Oversight.** We may disclose your information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the healthcare system, government benefit programs, or other government regulatory programs. For example, we may disclose information to the state agency that issues our practice license.
6. **Abuse or Neglect.** We may disclose your personal health information to a governmental agency authorized to receive such information if we believe that you have been a victim of abuse, neglect, or domestic violence. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
7. **Legal Proceedings.** We may disclose your personal health information for judicial and administrative proceedings, such as responding to a subpoena or court order.
8. **Law Enforcement.** We may disclose your personal health information for law enforcement purposes, such as providing limited information to locate a missing person, reporting certain types of wounds, and reporting crimes that occur on our property.
9. **Coroners, Funeral Directors, and Organ Donation.** We disclose your information to a coroner or medical examiner in order for them to perform their legal duties such as making identification and determining cause of death. We disclose your information to funeral directors to permit them to carry out their duties. We also are required to disclose your information for organ donation. You or your family must approve organ donations.
10. **Research.** We may disclose your personal health information for research studies that meet all privacy law requirements such as research related to the prevention of disease or disability.
11. **Criminal Activity.** We may disclose your information if we believe it is necessary to prevent or lessen a serious threat to health or safety. We may also disclose personal health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
12. **Military Activity and National Security.** If you are a member of the United States Military, we may disclose your information as required by military command authorities. We may disclose your personal health information for federal officials to conduct national security and intelligence activities, to protect the President or other specified people, or to conduct special investigations. We disclose information for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits.
13. **Workers' Compensation.** We may disclose your personal health information under workers' compensation laws and other similar programs.
14. **Inmates.** If you are in custody, we may disclose your personal health information to the correctional facility or the law enforcement official that maintains your custody.
15. **Your authorization is required for other uses and disclosures.** You must give us your written authorization before we disclose your personal health information for other uses. You may revoke an authorization at any time by contacting Community Medical Clinic. A revocation will not apply to any action we have taken in reliance on the authorization.

You have the opportunity to agree or object. You have the opportunity to agree or object to the use or disclosure of all or part of your personal health information as described below.

1. **Others Involved in Your Healthcare.** Unless you object, we may disclose your information to a relative, a close friend, or any other person you identify. We may also give out your information when it appears, under the circumstances, to be in your best interest to do so.
2. **Disaster Relief.** We may disclose limited information to an authorized entity to assist in disaster relief efforts if we cannot contact you.

3. **You have the right to access your information.** You may see and receive a copy of your personal health information. In some cases, we may deny your request. When required by law, we will give you an opportunity to have our denial reviewed.

   Under federal law, you may not inspect or copy certain records such as psychotherapy notes. Please contact our Compliance Officer if you have questions about access to your medical record.

4. **You have the right to limit what we use and disclose.** You may ask us to limit how we use and disclose your health information to provide treatment, to obtain payment, to operate our programs and business, and to communicate with your family, friends and others you have identified. Your request must state the specific restriction requested and to whom you want the restriction to apply. ***We are not required to agree to that request***.

   If Community Medical Clinic does agree to the requested restriction, we may not use or disclose your personal health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with Medical Records Department or the Compliance Officer.

5. **You have the right to confidential communications.** We will accommodate reasonable requests. However, we may require you to tell us how you will handle payment and give details about where and how to contact you. We will not ask you why you make this request. Please make this request in writing to our Compliance Officer or Clinic Manager.

6. **You have the right to amend your personal health information.** You may ask that we amend your personal health information. We may deny your request. If we deny your request, you can appeal the denial in writing. We will respond to your appeal in writing. Please contact the Medical Records Department or our Compliance Officer.
7. **You have the right to a list of disclosures.** You have the right to receive a list of those who received your personal health information from us during the six years before your request, as applicable.
   a. To carry out treatment, payment, and health care operations
   b. To persons involved in your care
   c. For national security or intelligence purposes
   d. To prisons or jails, if you are an inmate
   e. To you or someone you have formally asked to speak for you, such as a documented medical power of attorney, or heath care surrogate
   f. To those who get this information with your approval

Reporting a problem

If you believe we violated your privacy rights, you may let us know by contacting:

- The Patient Representative of Community Medical Clinic at **(270) 365-0227.**
- The Safety/Compliance Officer of Community Medical Clinic at **(270) 365-0227**, or
- By email at **MLEWIS@COMMUNITYMEDICALCLINIC.ORG**

Community Medical Clinic welcomes your feedback and concerns. We will not retaliate against anyone who makes a complaint.

Additional Information

We may collect information that is not described above. We may use and disclose your information in any manner that is consistent with the concepts described in this Notice or permitted by the privacy laws.

For additional information about our privacy policies, please contact our Safety/Compliance Officer, Martha Lewis at 270-365-0227 or by email at **mlewis@communitymedicalclinic.org**

Patient Care and Safety Concerns

Individuals are encouraged to contact Community Medical Clinic **by email at MLEWIS@COMMUNITYMEDICALCLINIC.ORG**, regarding patient care or safety concerns that appear to not have been addressed.

You may also report complaints or grievances to the Cabinet for Health Services Office of Inspector General at (270) 889-6052.

Office Hours: Monday thru Friday 7:30 a.m. to 5:30 p.m.

After hours: Please call 270-890-1489 or go to your nearest emergency room.

Thank you for Using Community Medical Clinic

-WHAT YOU SHOULD KNOW ABOUT HIV AND AIDS

What is AIDS?

AIDS is the **A**cquired **I**mmune **D**eficiency **S**yndrome—a serious illness that makes the body unable to fight infection. A person with AIDS is susceptible to certain infections and cancers. When a person with AIDS cannot fight off infection, this person becomes ill. These infections can eventually kill a person with AIDS.

What causes AIDS?

The human immunodeficiency virus (HIV) causes AIDS. Early diagnosis of HIV infection is important. If you have been told that you have HIV, you should get prompt medical treatment. In many cases, early treatment can enhance a person's ability to remain healthy as long as possible. Free or reduced cost anonymous and confidential testing with counseling is available at every local health department in Kentucky. After being infected with HIV, it takes between 2 weeks and 6 months before the test can detect antibodies to the virus.

How is the virus spread?

Sexual contact (oral, anal, or vaginal intercourse) with an infected person when blood, pre-ejaculation fluid, semen, rectal fluids, or cervical/vaginal secretions are exchanged.

Sharing syringes, needles, cotton, cookers, and other drug injecting equipment with someone who is infected.

Receiving contaminated blood or blood products (very unlikely now because blood used in transfusions has been tested for HIV antibodies since March 1985).

An infected mother passing HIV to her unborn child before or during childbirth and through breastfeeding.

Receipt of transplant, tissue/organs, or artificial insemination from an infected donor.

Needle stick or other sharps injury in a health care setting involving an infected person. Infections can sometimes be prevented by taking post exposure prophylaxis anti-retroviral drugs. Strict adherence to universal precautions is the best way to prevent exposures.

You cannot get HIV through casual contacts such as:

Sharing food, utensils, or plates

Touching someone who is infected with HIV

Hugging and shaking hands

Donating blood or plasma (this has **never** been a risk for contracting HIV)

Using public restrooms

Being bitten by mosquitos or other insects

Using tanning beds (always clean before and after use)

How can I prevent HIV/AIDS?

Do not share needles or other drug paraphernalia. Do not have sexual intercourse except with a monogamous partner whom you know is not infected and who is not sharing needles. If you choose to have sex with anyone else, use latex condoms (rubbers), female condoms or dental dams, and water based lubricants every time you have sex. Educate yourself and others about HIV infection and AIDS. **Pregnancy and HIV/AIDS**

Mothers can pass HIV infection to their babies during pregnancy, labor and delivery, and by the child ingesting infected breast milk.

Without treatment, about 25%, (1 out of 4) of the babies born to HIV infected women will get HIV.

Medical treatment for the HIV infected women during pregnancy, labor and delivery, can reduce the chance of the baby getting HIV from its mother to less than 2% (less than 2 out of 100).

An HIV infected mother should not breast feed her newborn baby.

What is unsafe sex?

Vaginal, anal, or oral sex without using a condom or dental dam.

Sharing sex toys.

Contact with HIV infected, pre-ejaculation fluid, semen, rectal fluids, or cervical/vaginal secretions.

What is safer sex?

Abstinence (not having sex of any kind).

Sex only with a person who does not have HIV, does not practice unsafe sex, or inject drugs.

Using either a male or female condom or dental dam (for oral sex).

How to use a latex condom:

1. Use a new latex condom every time you have sex.
2. The condom should be rolled onto the erect (hard) penis, pinching ½ inch at the tip of the condom to hold the ejaculation (semen) fluid. Air bubbles should be smoothed out.
3. Use plenty of WATER-BASED lubricants such as K-Y Jelly, including a drop or 2 inside the condom, before and during intercourse. **DO NOT USE** oil-based lubricants such as petroleum jelly, mineral oil, vegetable oil, Crisco, or cold cream.
4. After ejaculating, withdraw the penis holding the condom at the base so it will not slip off.
5. Throw away the used the condom into a garbage can and wash hands.

Remember: You can't tell whether or not someone has HIV just by looking at them

Is treatment available if I already have HIV/AIDS?
After being infected with HIV, it takes between 2 weeks and 6 months before antibody tests can detect HIV. **Early diagnosis of HIV infection is important!** If you have HIV, you should get prompt medical treatment. In many cases, early treatment can enhance a person's ability to remain healthy as long as possible. Your doctor will help determine the best treatment.

Getting tested for HIV:
If you have never been tested for HIV, you should be tested at least once. Free anonymous and confidential rapid antibody testing and counseling are available at every health department in Kentucky. Centers for Disease Control and Prevention (CDC) recommends **being tested at least once a year if you do things that can transmit HIV.** These include:
Injecting drugs or steroids with used injection equipment
Having sex with someone who has HIV or any sexually transmitted disease (STD)
Having more than one sex partner who has had other sex partners since your last HIV test
Having sex for money or drugs (prostitution-male or female)
Having unprotected sex or sex with someone who has had unprotected sex
Having sex with injection drug user(s)
Having had a blood transfusion between 1978 and 1985
Pregnant women or women desiring to become pregnant
This agency provides quality services to all patients, regardless of HIV status.

If you need more information call:
Kentucky HIV/AIDS Program: 502-564-6539

The National AIDS Hotline: 1-800-342-AIDS
Your local health department's HIV/AIDS Coordinator