203 EAST MAIN STREET
RICHMOND, IN 47374
PHONE # 765-973-9294
FAX # 765-973-9233

Welcome to Well Care Community Health, Inc.

Each patient of Well Care Community Health will be asked to complete a Sliding Fee Schedule application on an annual basis. The following information is requested to show proof of income:

1. Proof of household income. Examples: pay stubs-the 2 most current, child support, Social Security/Disability/SSI, Pension, TANF
   (Discounted fees available to patients who qualify based on household size and income).
2. Current picture ID, such as driver's license.
3. List of current prescription medication(s). You can write these on the Patient History sheet you were given.
4. Copy of current insurance card

Please have all the above information when you return these forms to the clinic to simplify the appointment process.

Information about the Clinic

Hours	**Evening Hours**	**Walk In Hours**
Monday-Friday	**By Appointment**	**Monday-Friday**
8:00 – 11:45 AM		**8:00 – 10:30 AM**
12:45 – 5:00 PM		**1:00 – 3:00 PM**

***We ask that you be on time for your appointment. If you are unable to keep your appointment, please call our office to reschedule or cancel within 24 hours of your appointment.**

To contact a health care worker by phone during business hours: Tel (765) 973-9294
TTY Users call: 711 or (800) 743-3333
***Telephone switchboard remains open for calls during lunch**

- Medical Appointment – **Press 1**
- Concerns regarding a recent appointment, test result, or medication – **Press 2**
- Immunizations – **Press 3**
- Medication Refill – **Press 4**
- Dental Appointment – **Press 5**
- To speak to an operator – **Press 0**

After Hours- If you have a medical problem or a question after business hours or during the weekend and you feel it cannot wait until our next business day, please call our on-call system at (765) 914-1859. Or you may call our main number (765) 973-9294 and push 9 to be transferred. A healthcare professional will call you back shortly.

Medication Refill- Call 973-9294 and push the option for medicine refills. Leave your name, phone number, medication name and dosage. Also, leave the name of a pharmacy where the prescription can be called if you do not get the medicine at the clinic. Due to the large volumes of calls, it may take 48 hours before the medicine is ready for pick up. Your call is very important to us.

Lab Hours- Monday – Friday- 8:00 - 11:00 A.M. or 1:00 - 3:00 P.M.

Calling for a Nurse – Please call (765) 973-9294 and push option 2 to speak to a Nurse. Leave a voicemail message with your name, phone number and a brief message and the nurse will return your call.

Appt. Date: ______________________________

Notes:

WELL CARE COMMUNITY HEALTH
203 EAST MAIN STREET
RICHMOND, IN 47374

SLIDING FEE ELIGIBILITY FORM
and Annual Update

Today's Date: ____________________

Name:
Address:
City, State:
Zip Code:
Telephone:
Social Security #:
Date of Birth:
EMR #:

It is necessary for us to ask personal questions to give you a discount on our medical expenses. This information will be kept on file in our Health Center and held in strict confidence You must verify your income at least annually. Your yearly income can be verified by one of the following: tax return, copy of your two (2) current pay stubs (within the past 3 months), disability check stub, SSI check stub, current unemployment check stub/statement, or child support check stub. Your annual income will be used to calculate the level of your payment.

Number of people living in your home: ☐

What is your marital status? ❑Married ❑Widow(er) ❑Single ❑Divorced ❑Separated

Amount of Gross Household Income:
(before taxes and other deductions)

You	Your Spouse	Your Children	Other Person	Total Family Income

Place of Employment:	You	Your Spouse	Your Children	Other Person
Veteran:	☐	☐	☐	☐

Do you receive any income from any of the following sources, and if so, how much?

Source	You	Your Spouse	Your Children	Other Person	Total Sources
Social Security					
Public Assistance					
Retirement Pension					

Do you have any type of insurance that will cover all or a portion of your medical expense? ❑ Yes, list below ❑ No

Give Names, DOB, and relationship of all individuals living in the household:

Name	Date of Birth (DOB)	Relationship to patient

I declare the above information is true and have given the Well Care Community Health, Inc. permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that if my income should change that I am required to notify the receptionist on my next visit to the clinic.

Signature: Print:	Date:	***Clinic Purpose Only:*** Income Code:

Name:______________________________________ Maiden Name:__________
First Middle Initial Last — or other name used

PATIENT INFORMATION

Race: ☐ American Indian/Alaska Native ☐ Black/African American ☐ Asian
☐ Native Hawaiian ☐ Other Pacific Islander ☐ More than (1)
☐ Unknown/Refused ☐ Caucasian

Ethnicity: ☐ Non Hispanic/Latino ☐ Hispanic/Latino ☐ Unknown/Refused

Language: ☐ English ☐ Spanish ☐ French
☐ Mandarin ☐ Japanese ☐ Other ______________

SS# ______________ Birth Date________ Marital Status: S M D W Sex: M F

Address____
Street City State Zip

List your contact number and √ your preferred contact method below:

Home ☐ ____________ Cell ☐ ____________ Portal ☐______________

Email Address ______________________________

SLIDING Fee Available upon request: ☐ Annual Income:__________ Size of Household: __________

Employer Name ______________________________ Status: F/T P/T Retired None

Employer Address ____
Street City State Zip

Student Status if applicable: Full-time Part-time Name of College/Univ/School______________

Primary Care Physician ______________________ Referred by ______________

Birth Mother's Full Name ____
First Middle Initial Last Maiden

INFORMATION FOR MINORS

Note: If the patient is a minor, please complete this section regarding financial responsibility

Guarantor Name ____

Address (if different from patient's) ____
Street City State Zip

EMERGENCY CONTACT INFO

Name ______________________ Relationship ____________ Phone__________

Please √ all that apply: ☐ May discuss my medical info ☐ May pick up my medications

Address____
Street City State Zip

Name ______________________ Relationship ____________ Phone__________

Please √ all that apply: ☐ May discuss my medical info ☐ May pick up my medications

Address____
Street City State Zip

INSURANCE INFORMATION

PRIMARY CO______________________ Policy/ID#______________Group__________

Insured Party: Self Spouse Parent Insured Name (if not the patient)______________________

Birth date __________ SS#____________ Employer____________ Emp Tel__________

SECOND CO______________________ Policy/ID#______________Group__________

Insured Party: Self Spouse Parent Insured Name (if not the patient)______________________

Birth date __________ SS#____________ Employer____________ Emp Tel__________

THIRD CO______________________ Policy/ID#______________Group__________

Insured Party: Self Spouse Parent Insured Name (if not the patient)______________________

Birth date __________ SS#____________ Employer____________ Emp Tel__________

I give my consent for Well Care Community Health, Inc. to use and disclose my protected health information (PHI) for treatement, payment, and health care options. The insurance information I have provided on this form is accurate and complete. If I have not listed insurance info., then I understand I am responsible for payment.

Patient or responsible party signature:______________________________ **Date:**__________

WELL CARE COMMUNITY HEALTH, INC

Health Questionnaire

Patient Name: ______________________ Birth Date: ________ Date: ____________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, may affect your oral health.

Question		
Are you under a physicians' care now?	○ Yes	○ No
If yes ____________________		
Have you ever been hospitalized or had a major operation?	○ Yes	○ No
If yes ____________________		
Have you ever had a serious head or neck injury?	○ Yes	○ No
If yes ____________________		
Are you taking any medications, pills, or drugs?	○ Yes	○ No
If yes ____________________		
Are you taking any blood thinners?	○ Yes	○ No
If yes ____________________		
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes	○ No
If yes ____________________		
Do you use tobacco?	○ Yes	○ No
If yes ____________________		
Do you use controlled substances?	○ Yes	○ No
If yes ____________________		

Women: Are You ....

○ Pregnant/Trying to get pregnant? ○ Nursing? ○ Taking oral contraceptives?

Are you allergic to any of the following?

○ Aspirin	○ Penicillin	○ Codeine	○ Acrylic
○ Metal	○ Latex	○ Sulfa Drugs	○ Local Anesthetics
○ Silver	○ Red Dye	○ Iodine	○ NONE
	○ Other?		

If yes ____

Do you have, or have you had, any of the following?

Condition	Response	Condition	Response	Condition	Response	Condition	Response
AIDS/HIV Positive	Yes ○ No ○	Cortisone Medicine	Yes ○ No ○	Hemophilia	Yes ○ No ○	Radiation Treatment	Yes ○ No ○
Alzheimer's Disease	Yes ○ No ○	Diabetes	Yes ○ No ○	Hepatitis A	Yes ○ No ○	Hepatitis B or C	Yes ○ No ○
Anaphylaxis	Yes ○ No ○	Drug Addiction	Yes ○ No ○	Renal Dialysis	Yes ○ No ○	Anemia	Yes ○ No ○
Herpes	Yes ○ No ○	Rheumatic Fever	Yes ○ No ○	Angina	Yes ○ No ○	Emphysema	Yes ○ No ○
High Blood Pressure	Yes ○ No ○	Arthritis	Yes ○ No ○	Epilepsy or Seizures	Yes ○ No ○	Scarlet Fever	Yes ○ No ○
Artificial Heart Valve	Yes ○ No ○	Excessive Bleeding	Yes ○ No ○	Hives or Rash	Yes ○ No ○	Shingles	Yes ○ No ○
Artificial Joint	Yes ○ No ○	Excessive Thirst	Yes ○ No ○	Hypoglycemia	Yes ○ No ○	Sickle Cell Disease	Yes ○ No ○
Asthma	Yes ○ No ○	Fainting Spells/Dizziness	Yes ○ No ○	Irregular Heartbeat	Yes ○ No ○	Sinus Trouble	Yes ○ No ○
Blood Disease	Yes ○ No ○	Kidney Problems	Yes ○ No ○	Spina Bifida	Yes ○ No ○	Blood Transfusion	Yes ○ No ○
Leukemia	Yes ○ No ○	Stomach/Intestinal	Yes ○ No ○	Breathing Problems	Yes ○ No ○	Frequent Headaches	Yes ○ No ○
Liver Disease	Yes ○ No ○	Stroke	Yes ○ No ○	Bruise Easily	Yes ○ No ○	Low Blood Pressure	Yes ○ No ○
Swelling of Limbs	Yes ○ No ○	Cancer	Yes ○ No ○	Glaucoma	Yes ○ No ○	Lung Disease	Yes ○ No ○
Thyroid Disease	Yes ○ No ○	Chemotherapy	Yes ○ No ○	Mitral Valve Prolapse	Yes ○ No ○	Tonsillitis	Yes ○ No ○
Chest Pains	Yes ○ No ○	Heart Attack/Failure	Yes ○ No ○	Osteoporosis	Yes ○ No ○	Tuberculosis	Yes ○ No ○
Cold Sores/Fever blisters	Yes ○ No ○	Heart Murmur	Yes ○ No ○	Pain in Jaw Joints	Yes ○ No ○	Congenital Heart Disorder	Yes ○ No ○
Heart Pacemaker	Yes ○ No ○	Parathyroid Disease	Yes ○ No ○	Convulsions	Yes ○ No ○	Heart Trouble/Disease	Yes ○ No ○
Psychiatric Care	Yes ○ No ○	Venereal Disease	Yes ○ No ○	Yellow Jaundice	Yes ○ No ○	Recent Weight Loss	Yes ○ No ○

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes ____________________

If any blood relative has suffered any of the above, please list below.

____

____

____

____

____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the dental/medical staff if I, or my minor child, ever have a change in medical or dental health. I give my consent for the Well Care Community Health, Inc. to use and disclose my protected health information (PHI) for treatment, payment, and health care options (TPO). I have received a copy of the Notice of Privacy Practices. The Clinic may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements, insurance items, and any calls pertaining to my clinical care, including test results. I have the right to request the Clinic to restrict how it uses or discloses my PHI, however, the practice is not required to agree to my restrictions.

X ______________________________ ______________

Signature of Patient, Patient or Guardian Date

X ______________________________

Relationship to Patient if signed by Guardian

Medical
Dental
Behavioral

Patient Consent for Care Form

Consent to Care:
I, the undersigned, for myself or a minor child/children or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through Well Care Community Health on an outpatient/ office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary.

To the Patient:
You have the right to discuss the treatment plan with your health care provider about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Signed Consent

I hereby give my consent to treat minor child/children below, which is under the legal age of eighteen years of age, to receive medical care and/or treatment from the providers of Well Care Community Health. Any care deemed medically necessary may be provided with our without my presence:

Child: ______________________________ Date of birth: ______________

Child: ______________________________ Date of birth: ______________

Child: ______________________________ Date of birth: ______________

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

______________________________ ______________________
Signature of Patient or Legal Guardian Date

______________________________ ______________________
Printed Name of Patient or Legal Guardian Relationship to Patient

This consent to medical treatment will remain in effect from the date signed until revoked in writing.

WELL CARE COMMUNITY HEALTH, INC

Effective date: 6.1.2020

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DISCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

If you have any questions about this notice, please contact Kimberly Flanigan, RN at the Health Center at 765.973.9294 or 203 E Main St Richmond IN 47374

WHO WILL FOLLOW THIS NOTICE

This notice describes information about privacy practices followed by our employees, staff, and other Health Center personnel. When your provider is not available, the healthcare providers you consult with by telephone who provide "call coverage" for him/her will follow the practices described in this notice.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the healthcare and services you receive at the Health Center.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT 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, Health Center staff or other personnel who are involved in taking care of you and your health.

For example, your provider may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The provider may use your medical history to decide what treatment is best for you. The provider may also tell another provider about your condition so that can help determine the most appropriate care for you.

Different personnel at the Health Center may shore information about you and disclose information to people who do not work at the Health Center to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering X-rays. Family members and other healthcare providers may be part of your medical care outside the Health Center and may require information about you that we have.

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

For Healthcare Operations. We may use and disclose health information about you to run the Health Center and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders. We may contact you as a reminder that you have an appointment for treatment or medical care at the Health Center.

Treatment Alternatives. We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services. We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations.

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.

Required by Law. We will disclose health information about you when required to do so by federal, state, or local law.

Research. We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission so the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care at the Health Center.

Organ and Tissue Donation. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security, and Intelligence. If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Worker's Compensation. We may release health information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose health information about you for public health reasons to prevent or control disease, injury, or disability, or report births, deaths, suspect abuse or neglect, non-accidental physical injuries, reactions to medication or problems with products.

Health Oversight Activities. We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the healthcare system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement. We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors. We may release 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.

Information Not Personally Identifiable. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends. We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgement that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgement, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgement and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization.* We must obtain you *Authorization.* If you give *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

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 your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to Kimberly Flanigan, RN, COO to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend. If you believe health information we have about you is incorrect or incomplete, you may ask to amend the information. You have the right to request an amendment if the Health Center keeps the information.

To request an amendment, complete and submit a Medical Record/Amendment/Correction Form to Kimberly Flanigan, RN, COO. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request.

a. In addition, we may deny your request if you ask us to amend information that:
b. We did not create, unless the person or entity that created the information is no longer available to make the amendment.
c. Is not part of the health information that we keep.
d. You would not be permitted to inspect and copy.

e. Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for the purposes other than treatment, payment, and healthcare operations. To obtain this list, you must submit your request in writing to Kimberly Flanigan, RN, COO. It must state a time, which may not be longer that six years and may not include dates before April 14, 2003. Your request should include in what form you want the list (example, on paper or electronically). We may charge 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 Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Health Center or the Secretary of the Department of Health and Human Services. To file a complaint with the Health Center, contact Kimberly Flanigan, RN, COO at 765.976.9294. You will not be penalized for filing a complaint.

NOTICE OF PRIVACY PRACTICES: ACKNOWLEDGEMENT OF RECEIPT AND DESIGNATION OF PERSONAL REPRESENTATIVE

Patient Name:________________________________ Date of Birth:___________

Acknowledgement:

I hereby acknowledge that I received and/or was offered a copy of this practice's Notice of Privacy Practices:

Signed:____________________________________ Date:_________________

Print Name:_________________________________ Phone:________________

If not signed by the patient, please indicate relationship:____________________________

Designation ☐ **Declined** ☐ **Revised**

I authorize the practice to disclose or provide my protected health information to the following individual(s) who is (are) authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent to authorize the use or disclosure of my protected health information:

_______________________________ _______________________________

(Printed Name of Personal Representative) (Phone Number)

_______________________________ _______________________________

(Printed Name of Personal Representative) (Phone Number)

_______________________________ _______________________________

(Printed Name of Personal Representative) (Phone Number)

Description of information to be disclosed: I authorize the practice to disclose all of my protected health information to my designated personal representative(s).

Expirations or termination of authorization: This authorization will remain in effect until terminated by you or your personal representative(s).

Right to revoke or terminate: As stated in our Notice of Practice Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager.

Redisclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed to your personal representative will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

_______________________________ _______________________________

Signature Date