

Well Care Community Health, Inc
203 East Main Street
Richmond, IN 47374
Phone #765.973.9294 Fax #765.973.9233
TTY users call 711 or 800.325.0778

Welcome to the Well Care Community Health, Inc.

Prior to or at the time of your appointment

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. Picture ID, such as driver's license.
3. List of current prescription medication. 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.

Information about the Clinic

Hours

Monday-Friday

8:00-11:45 am 12:45-5:00 pm

Evening Hours

By appointment

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

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 the following number: 765.914.1859

Medication Refill - Call 973.9294 and select option 4 for medicine refills. Leave your name, phone number, medication name and dosage. The name of a pharmacy where the prescription can be called if you do not get the medicine at the Clinic.

Lab Hours - Monday - Friday 8:00 - 11:00 am or 1:00 - 3:00 pm

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

Well Care Community Health, Inc.

To Contact a Health Care Worker by Phone During Business Hours:

PHONE NUMBER: 765.973.9294

(Telephone Switchboard remains open for calls during lunch)

TTY Users Call: 711 or 800.325.0778

- Appointments - Press 1
- Triage Nurse - Press 2
- Immunizations - Press 3
- Medication Refill - Press 4
- Dental Appointments - Press 5
- Spanish Interpreter - Press 7
- After Hours On Call - Press 9
- To speak to an Operator - Press 0

Business Hours:

Monday - Friday 8:00 am - 5:00 pm

Doors closed for lunch 11:45 am - 12:45 pm

(Telephone Switchboard remains open for calls during lunch)

Evening Hours Available

By appointment

After Business Hours Call:

To contact a healthcare worker after hours, please call **765.914.1859**

Appt. Date: _____

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

Notes:

**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

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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:	Date:	<i>Clinic Purpose Only:</i>
Print:		Income Code:



Name: _____ Maiden Name: _____

First Middle Initial Last or other name used

PATIENT INFORMATION	Race:	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Asian
		<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> More than (1)
		<input type="checkbox"/> Unknown/Refused	<input type="checkbox"/> Caucasian	
	Military	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Ethnicity:	<input type="checkbox"/> Non Hispanic/Latino	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Unknown/Refused
	Language:	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> French
		<input type="checkbox"/> Mandarin	<input type="checkbox"/> Japanese	<input type="checkbox"/> 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 <input type="checkbox"/>	Cell <input type="checkbox"/>	Portal <input type="checkbox"/>	
Email Address _____				
SLIDING Fee Available upon request: <input type="checkbox"/> 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: <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Caregiver <input type="checkbox"/> Next of kin
	Address _____
	Street City State Zip
	Name _____ Relationship _____ Phone _____
	Please √ all that apply: <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Caregiver <input type="checkbox"/> Next of kin
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 treatment, 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: _____

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.

Are you under a physicians' care now? If yes _____	<input type="radio"/> Yes	<input type="radio"/> No
Have you ever been hospitalized or had a major operation? If yes _____	<input type="radio"/> Yes	<input type="radio"/> No
Have you ever had a serious head or neck injury? If yes _____	<input type="radio"/> Yes	<input type="radio"/> No
Are you taking any medications, pills, or drugs? If yes _____	<input type="radio"/> Yes	<input type="radio"/> No
Are you taking any blood thinners? If yes _____	<input type="radio"/> Yes	<input type="radio"/> No
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? If yes _____	<input type="radio"/> Yes	<input type="radio"/> No
Do you use tobacco? If yes _____	<input type="radio"/> Yes	<input type="radio"/> No
Do you use controlled substances? If yes _____	<input type="radio"/> Yes	<input type="radio"/> No

Women: Are You

<input type="radio"/> Pregnant/Trying to get pregnant?	<input type="radio"/> Nursing?	<input type="radio"/> Taking oral contraceptives?
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Are you allergic to any of the following?

<input type="radio"/> Aspirin	<input type="radio"/> Penicillin	<input type="radio"/> Codeine	<input type="radio"/> Acrylic
<input type="radio"/> Metal	<input type="radio"/> Latex	<input type="radio"/> Sulfa Drugs	<input type="radio"/> Local Anesthetics
<input type="radio"/> Silver	<input type="radio"/> Red Dye	<input type="radio"/> Iodine	<input type="radio"/> NONE
<input type="radio"/> Other?			

If yes _____

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

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

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.
203 East Main Street
Richmond, IN 47374
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EMERGENCY CONTACT INFORMATION

Patient Name:

Date of Birth:

Email Address:

Emergency Contact Name:	Relationship:
Phone Number #1:	# 2:
<input type="checkbox"/> May discuss my medical information	<input type="checkbox"/> May pick up my medications

Emergency Contact Name:	Relationship:
Phone Number #1:	# 2:
<input type="checkbox"/> May discuss my medical information	<input type="checkbox"/> May pick up my medications

Signature: _____

Date: _____

Patient ID #: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES 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 share 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 your *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 than 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.

Well Care Community Health, Inc.

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Staff Witness Signature: _____ Title: _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason:
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WELL CARE COMMUNITY HEALTH

PATIENT SATISFACTION SURVEY

Well Care Community Health Patient Satisfaction Survey We would like to know how you feel about the services we provide so we can make sure we are meeting your needs. Your responses are directly responsible for improving these services. All responses will be kept confidential and anonymous. Thank you for your time.

Please select your age group:

Under 18	<input type="checkbox"/>	55 to 64	<input type="checkbox"/>
18 to 24	<input type="checkbox"/>	65 to 74	<input type="checkbox"/>
25 to 34	<input type="checkbox"/>	75 or older	<input type="checkbox"/>
35 to 54	<input type="checkbox"/>		

Are you male or female?

Male	<input type="checkbox"/>
Female	<input type="checkbox"/>

What do you consider to be your primary racial group?

White	<input type="checkbox"/>	Asian	<input type="checkbox"/>
Hispanic or Latino	<input type="checkbox"/>	Native Hawaiian or Other Pacific Islander	<input type="checkbox"/>
Black or African American	<input type="checkbox"/>	Two or more races	<input type="checkbox"/>
American Indian or Alaska Native	<input type="checkbox"/>	Some Other Race	<input type="checkbox"/>

Please circle how well you think we are doing in the following areas:
 GREAT (5), GOOD (4), OK (3), FAIR (2), POOR (1)

Ease of getting care:

	Great (5)	Good (4)	OK (3)	Fair (2)	Poor (1)
Ability to get in to be seen:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hours Center is open:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convenience of Center's location:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prompt return on calls:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Waiting:

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	Great (5)	Good (4)	OK (3)	Fair (2)	Poor (1)
Time in waiting room:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Time in exam room:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiting for tests to be performed:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiting for test results:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Provider (Physician, Dentist, Physician Assistant, Nurse Practitioner) Staff:

	Great (5)	Good (4)	OK (3)	Fair (2)	Poor (1)
Provider listens to you:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provider takes enough time with you:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provider explains what you want to know:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provider gives you good advice and treatment:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Nurses and Medical Assistants:

	Great (5)	Good (4)	OK (3)	Fair (2)	Poor (1)
Friendly and helpful to you:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Answers your questions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Staff:

	Great (5)	Good (4)	OK (3)	Fair (2)	Poor (1)
Friendly and helpful to you:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Answers your questions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Payment:

	Great (5)	Good (4)	OK (3)	Fair (2)	Poor (1)
What you pay:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Explanation of charges:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Collection of payment/money:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Facility:

	Great (5)	Good (4)	OK (3)	Fair (2)	Poor (1)
Neat and clean building:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ease of finding where to go:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comfort and safety while waiting:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Privacy:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Confidentiality:

	Great (5)	Good (4)	OK (3)	Fair (2)	Poor (1)
Keeping my personal information private:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The likelihood of referring your friends and relatives to us:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you consider this clinic your main source of care?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

What do you like best about our Center? What do you like least about our Center? Suggestions for improvement?

Thank you for completing our Survey!

WELL CARE COMMUNITY HEALTH
PATIENT SATISFACTION SURVEY
