Annual Consent for Care

Patient Name:_____ Patient Date of Birth:_____

This consent form applies to Knox County Community Health Center (KCCHC) operating as a clinically integrated health care arrangement composed of KCCHC and practitioners collectively. All of the entities owned or operated by KCCHC and all practitioners associated with KCCHC will share medical information of patients as necessary to carry out treatment, payment and health care operations as permitted state and federal by law. The KCCHC offers medical, dental, mental health and behavioral health services that I may utilize as a patient of the KCCHC.

CONSENT FOR MEDICAL CARE: I understand that I have the right to make informed decisions about my health care treatment. I consent to have the health care professionals at KCCHC perform the appropriate services and treatments, which may include routine diagnostic procedures and such medical / dental treatment as the named attending practitioner or other member of the medical / dental staff consider to be necessary. I understand that the practice of medicine / dental / behavioral health is not an exact science and that diagnosis and treatment may involve risks, injury, or even death. I acknowledge that no guarantees have been made to me as the result of any examination or treatment. I understand that it is customary that no substantial procedures are performed upon a patient unless and until have had had an opportunity to discuss them with the practitioner or other health professional and the patient has given their informed consent for that particular procedure. Each patient has the right to consent, or to refuse consent, to any proposed procedure or therapeutic course. I understand that my health care practitioner work as a team, and that in order to provide me with the best care, my attending practitioner and other health practitioners may consult with or make referrals to practitioner in other specialties, as appropriate, such as other Physicians, Dentists / Oral Surgeons, Pharmacists, Dieticians and/or Therapists, etc., including obtaining my medication history from various prescription databases. I know that I can ask any KCCHC health care professional that treats me questions about my treatment.

I understand that some medical practitioners on the staff of the KCCHC are not employees or agents of the KCCHC but are independent contractors who have been granted the privileges of using the facilities for the care and treatment of their patients.

KCCHC participates in one or more Health Information Exchanges. Your healthcare practitioners can use this electronic network to securely provide access to your health records for a better picture of your health needs. KCCHC, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment, or other healthcare operations in accordance with Federal regulations. This is a voluntary agreement. You may opt-out at any time by notifying the KCCHC office administrator.

ASSIGNMENT OF INSURANCE BENEFITS: I understand that charges are made for KCCHC services provided by the health center staff and its Affiliated Physicians / Dentists and Behavioral Health practitioners. These charges are covered by insurance or other third-party reimbursement of any type, I hereby authorize assignment of these benefits to KCCHC and its Affiliated Physicians / Dentists. I further authorize the KCCHC to release any information from my medical/dental records to medical assistance, Medicaid, Medicare, other governmental payers, private insurance companies or plans or organizations acting on their behalf, as may be necessary to determine benefits and process claims and others involved in the collection of accounts.

It is the policy of the KCCHC to provide essential medical, mental health, behavioral health and dental services regardless of the patient's ability to pay. I understand and agree that some services rendered are based on my ability to pay. If qualified, a discount may be applied to co-payment, co-insurance, and/or deductible balances that are greater than the nominal fee. To qualify for the "sliding fee scale", I must provide proof of household income and the household occupancy. If payment for other services is determined by and based on a sliding fee scale, I understand that I am responsible for my share of the cost of services rendered at the time of service and that failure to provide "proof of income" will result in me being charged 100% of the cost of services received and/or provided. I further understand that failure to comply with my responsibilities for payment of services rendered may result in suspension of appointments.

ATTENTION PARENTS & GUARDIANS: If you are signing on behalf of a minor (defined as a patient 18 years old or under in most treatment situations), please be aware that under certain circumstances, state and federal laws may determine that the minor controls the protected health information relating to certain aspects of the minors care or treatment. In this event, KCCHC may not release the applicable protected health information without the minor's written consent.

By signing below, I acknowledge that I have read and understood this form, or had this form read and explained to me. I understand that I have the right to revoke/withdraw this consent, in writing, at any time. My revocation will be effective except to the extent KCCHC has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

_____	_____	_____
Signature of Patient/Responsible Party	Relationship (if not the patient)	Date

Revised 08/16/2022; 09/12/2022; 06/2024
Created 01/01/2020

KNOX COUNTY COMMUNITY Health Center
KNOX PUBLIC HEALTH

PATIENT INFORMATION REGISTRATION FORM: Complete all sections

Please check all services that are requesting:

☐ **Dental** ☐ **Behavioral Health** ☐ **Primary Medical Care**

PATIENT INFORMATION:

Last name	First Name	MI	Preferred Name	Social Security #	Birthdate	Birth Sex

BILLING ADDRESS of Patient or Responsibility Party	City	State	Zip

MAILING ADDRESS	City	State	Zip

Phone ( )	Alternate Phone ( )	Email address:

We utilize phone calls, texting and email for appointment reminders. A written request will be necessary if you do not want to receive one of the above.

How did you hear about us? ○ Patient ○ Newspaper ○ Internet ☐ Radio ○ Flyer ○ Billboard ○ Community Event ○ Other

Emergency Contact

Last Name	First Name
Relationship to Patient	Emergency Contact Phone Number:

Race: ○ White ○ Black/African American ○ Asian ○ Asian Indian ○ American Indian/Alaska Native ○ Native Hawaiian ○ Other Pacific ○ Chinese ○ Filipino ○ Guamanian/Chamorro ○ Japanese ○ Korean ○ Vietnamese ○ Samona ○ Asian Indian ○ Other Asian ○ More than one Race ○ Other (Please specify)_____

Ethnicity: ○ Not Latino/Hispanic or another Spanish orign ○ Mexican, Mexican American, Chicano/a ○ Cuban ○ Puerto Rican ○ Another Hispanic, latino/a, or Spanish orign ○ Refuse to Answer

Preferred language: ○ English ○ Spanish ○ French ○ Sign Language ○ German ○ Russian Other:_____

Marital Status: ○ Single ○ Married ○ Widowed ○ Legally Separated ○ Divorced ○ Life Partner ○ Other_____

Occupation: What is your current work situation? ○ Unemployed ○ Part-Time or temporary work ○ Full-time employment ○ Otherwise, unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver)
Please explain:_____ ○ I choose not to answer this question.

Are you a Veteran? ○ Yes ○ No Are you a **Migrate Worker**? ○ Yes ○ No ○ Seasonal

Living Arrangements: Are you homeless? ○ Yes ○ No If yes, where are you living? ○ Permanent Residence ○ Shelter ○ Transitional ○ Doubling up ○ Street ○ Other

Do you live within Mount Vernon City limits? ○ Yes ○ No

What **Advanced Directives** do you have: ○ Living Will ○ Durable Power of Attorney ○ Health Care Proxy ○ None ○ Decline to answer ○ Legal Guardian
If Yes, please specify who & their relation to you and proivide a copy of document:_____

KNOX COUNTY COMMUNITY Health Center
KNOX PUBLIC HEALTH

PATIENT INFORMATION REGISTRATION FORM: Complete all sections

For Patients 16 and Older ONLY
Sexual Orientation: ○ Straight or Heterosexual ○ Lesbian, Gay or Homosexual ○ Bisexual
○ Something else (please specify)_____ ○ Don't Know ○ Decline to answer

For Patients 16 and Older ONLY
Gender at Birth: ○ Male ○ Female ○ Other:_____

Current Gender Identity: Do you think of yourself as: ○ Male ○ Female ○ Transgender (please specify): Female-to-Male or Male-to-Female ○ Genderqueer, neither exclusively male nor female

○ Other/Additional gender category:_____ ○ Unknown ○ Decline to answer

Complete if patient is 18 years of age or younger, attending school, or has a legal guardian:
For all minor patients (18 years of age or under), legal guardians will be asked to show documentation to prove that a legal relationship exists. This is for both the safety of the child and guardian and to ensure that the legally appointed parent or guardian is responsible for making medical decisions on behalf of the minor. Applicable legal documents pertaining to custody, divorce, separation, adoption or name change of parent of child are required.

Parent / Guardian Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

Current Custody Status ○ Parents ○ Sole Parental Custody ○ Joint Legal Custody ○ DSS Custody ○ Other

Mailing Address (if different than patient): _____

INFORMATION FOR STATISTICAL REPORTING ONLY:

List number of people living in house (Please include self):_____

Annual Household Income (please check one): ○ Less than $15,000 ○ $15,000 to $24,999
○ $25,000 to $34,999 ○ $35,000 to $49,000 ○ $50,000 or more

To the best of my knowledge, the above information is complete and correct. I understand that I am responsible to let the doctor or staff know of any changes in my, or minor child's health, or demographic information.
I understand that I am responsible for notifying Knox County Health Center if there is a change in the insurance coverage, address or telephone number. I acknowledge that co-payments or nominal fees are due and payable on the day that services are received.
Name of Patient / Responsible Party (please print): _____ **Date:** _____
Signature of Patient / Responsible Party: _____ **Date:** _____

Annual Review: (***DO NOT*** complete this section – for staff instructed use only)

Signature of Patient / Responsible Party: _____ **Date:** _____

KNOX COUNTY COMMUNITY Health Center KNOX PUBLIC HEALTH

PRAPARE

Patient Name:_____Date ofBirth:_____

Are you worried about losing your housing? ◯ Yes ◯ No ◯ I choose not to answer this question	Are you a refugee? ◯ Yes ◯ No ◯ I choose not to answer this question
Do you feel physically and emotionally safe where your current live? ◯ Yes ◯ No ◯ I chose not to answer this	In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility? ◯ Yes ◯ No ◯ I chose not to answer this
What is the highest level of school that you have finished? ◯ Less than high school degree ◯ High school diploma or GED ◯ More than high school ◯ I choose not to answer the question	Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you? ◯ Not at all ◯ A little bit ◯ Somewhat ◯ Quite a bit ◯ Very much ◯ I choose not answer the question
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply. ◯ Yes, it has kept me from medical appointments ◯ Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need ◯ No ◯ I choose not to answer this question	How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings) ◯ Less than once a week ◯ 1 or 2 times a week ◯ 3 to 5 times a week ◯ 5 or more times a week ◯ I choose not to answer this question
In the past year, have you or any family members you live with been unable to get any of the following when it was **really needed**? Check all that apply. ◯ Yes ◯ No Food ◯ Yes ◯ No Utilities ◯ Yes ◯ No Clothing ◯ Yes ◯ No Phone ◯ Yes ◯ No Child Care ◯ Yes ◯ No Medicine or Any Health Care (Medical, Mental Health, Dental, Vision) ◯ Yes ◯ No Other (please write)_____ ◯ I chose not to answer	In the last year, have you been afraid of your partner or ex-partner? ◯ Yes ◯ No ◯ Unsure ◯ I have not had a partner in the past year ◯ I chose not to answer this

KNOX COUNTY COMMUNITY Health Center KNOX PUBLIC HEALTH

Patient Medical and Dental History

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

Allergies: I do not have any allergies. _____ (Initial)

I have the following drug, environmental or food allergies (Write name and effect you had)

Drug / Environmental / Food Allergy	***What happens*? (reaction)**

Are you currently pregnant? ○ No ○ Yes

Would you like to become pregnant within the next 12 months? ○ No ○ Yes

Medical History: Check if you have or have had problems / history with any of the following:

Cardiac
- ○ Heart Attack
- ◉ High Blood Pressure
- ○ High Cholesterol
- ○ Irregular Heart Beat
- ○ Stroke / TIA
- ○ Heart Transplant
- ○ Artificial Heart Valves
- ○ Pacemaker

Circulatory
- ○ Amputee
- ○ Blood Clots
- ○ Peripheral Artery Disease
- ○ Peripheral Vascular Disease

Dental
- ○ Bleeding Gums
- ○ Grinding Teeth
- ○ Loose Teeth / Broken Fillings
- ○ Periodental Treatment
- ○ Tooth Sensitivity

Endocrine
- ○ Thyroid Disease
- ○ Diabetes

Gastroenterology
- ○ Bleeding Ulcers
- ○ Diverticulitis
- ○ Gallbladder
- ○ GERD
- ○ Hernia

Immune
- ○ Lupus
- ○ Rheumatoid Arthritis

Infectious Disease
- ○ HIV
- ○ MRSA
- ○ VRE
- ○ Hepatitis

Lungs
- ◉ Asthma
- ◉ COPD
- ◉ Obstructive Sleep Apnea
- ○ Pulmonary Embolism
- ○ Tuberculosis
- ○ Lungs

Neurology
- ○ Seizures

Mental / Behavioral Health
- ○ ADD / ADHD
- ○ Anxiety
- ○ Depression
- ○ Traumatic Event / PTSD
- ○ Other: _____
- ○ Additions:_____

Musculoskeletal
- ○ Arthritis
- ○ Gout
- ○ Open Wounds
- ○ Osteoprorsis

Renal
- ○ Dialysis
- ○ Kidney Disease

Cancer
- ○ No history of cancer
- ○ Yes, prior history of cancer
- ○ If Yes: Type: _____ _____

Surgeries:

Example: Right knee replacement	*When?* 6 years ago

Signature of Patient or Parent/Guardian (If patient is minor): _____ **Date** _____

KNOX COUNTY COMMUNITY Health Center KNOX PUBLIC HEALTH

Annual Patient Medication/Drug List

Patient's Name:_____ Date Of Birth: _____

ALL PATIENTS: This information will be held **strict confidence** and will be used only for safe and appropriate care. Please provide the medication/drug name, the dosage you take, and the frequency of which you take the medication drug.

Medication used during treatment may interact with both prescription and non-prescription drugs; including herbal supplements. These reactions may result in **SEVERE INTERACTIONS.** It is **extremely** important that you inform your provider of **any** drug you currently use or may have taken so that this may be considered in planning your treatment.

Foster's Pharmacy, Conway's Pharmacy and **Wal-Mart of Mt. Vernon** are preferred by the Health Center. Most prescriptions are electronically transmitted for your convenience. Please list **Foster's Pharmacy, Conway's, Wal-Mart** or another pharmacy you prefer.

Pharmacy Name:_____ Pharmacy Town:_____

Medication:	Dose	How often	Why do you take it?

Print Name of Patient or Responsible Party:_____ Date:_____

Signature of Patient or Responsible Party:_____ Date: _____

Created 04/2024

HIPAA Release Form

Patient Name:_____ Patient Date of Birth:_____

I understand and have been provided with a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used and disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that KCCHC reserves the right to change their notice and information practices and that I may obtain a revised copy of the notice by requesting one from the health center.

I have the right to revoke this consent by notifying KCCHC in writing, except to the extent that KCCHC has taken action in reliance on my consent.

List names of people that doctor/nurse practitioner can talk to about your health information:

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

I understand that KCCHC will not discuss my medical care or billing information with anyone not listed on this account.

I understand that this consent supersedes any other consent that may have been signed.

_____	_____
Signature of Patient or Patient's Respresentative	Date
_____	_____
Printed Name of Patient or Patient's Representative	Relationship to Patient or Authority to act on behalf of the patient

KCCHC has my permission to leave a message on my contact phone numbers/answering machine or cell phone regarding my healthcare needs. ◯Yes ◯ No _____Initials

This consent will expire one year from date signed.

Created: 04/12/2024

Patient No-Show
Appointment Cancellation Policy

To Our Valued Patients: We strive to provide excellent care to our patients. To provide quality care to all patients we enforce a Patient No-Show and Cancellation Policy. All appointments are to be canceled 24 hours before your appointment time. To cancel your appointment, please call 740-399-8008 and leave your name, date of birth and the appointment date and time you need to cancel.

Medical/Dental/Behavioral Health:

If your appointment is cancelled less than 24 hours prior to your appointment time, arrive to an appointment more than 10 minutes late, or you, simply do not show up to your scheduled appointment, you will be considered a "no-show" for that appointment.

After three (3) cancelled appointments and/or no-show appointments in a six (6) month period, you will only be permitted to use the Health Center on walk-in basis for 6 months.

Oral Surgery Services:

After **ONE** no-show appointment with the oral surgeon you will be moved to the wait list until there is availability

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Parents and Guardians:

If you are a parent or guardian of a minor, you are responsible for the minor's appointments and the same process will be used for a minor's no-show appointment.

I have read and understand the Patient No-Show and Cancellation Policy for the Knox County Community Health Center(s).

Print Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if under 18): _____ Date: _____

Created On: 09/13/2017; Revised: 1/1/2020; Revised: 8/8/2022;
Revised 04/08/2024

KNOX COUNTY COMMUNITY Health Center
KNOX PUBLIC HEALTH

CONSENT TO USE AI SCRIBE DURING ENCOUNTERS

Patient Name_____ Date of Birth_____

We are committed to providing the best possible care for you, and as part of this commitment, we are continually looking for ways to enhance our services.

We would like to inform you about a new technology that we are using called AI scribe. AI Scribe is an artificial intelligence (AI tool that assists us during patient encounters by generating clinical notes based on our conversations. This tool allows us to focus more on you, the patient, and less on computer documentation. The AI tool does not interact with you directly. It merely listens to the conversation and creates a summary.

AI scribe is a tool that listens to the conversation during the consultation and generates a written summary or "note" based on that conversation. This note is then reviewed and approved by your practitioner.

We want to assure you that your privacy is our utmost priority. The AI tool adheres strictly to Health Insurance Portability and Accountability Act (HIPAA) compliance guidelines to ensure your data is secured and protected. Only the healthcare professionals involved in your care will have access to these notes.

Your participation is completely voluntary. If you agree to use the AI scribe during your consultations, please sign and date the form below. If you have any questions, please feel free to discuss them with us.

I, _____, consent to the use of AI Scribe during my medical encounters/appointments.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if under 18): _____ Date: _____

Created: 06/26/2024

KNOX COUNTY COMMUNITY Health Center
KNOX PUBLIC HEALTH

Informed Consent for Telehealth Services

Medical / Dental / Behavioral Health

I, _____, consent to engaging in telehealth services with the Knox County Community Health Center (KCCHC) as a part of the medical, dental or behavioral health services' offerings. I understand that telehealth services may include evaluation, assessment, consultation and/or treatment planning, and therapy. It has been explained how telehealth will be used and that is not the same as a direct patient / healthcare provider visit. Telehealth will occur primarily through telephonic, interactive audio and/or video communications.

By signing this consent, I am verifying that I understand the following:

1. I have the right to withhold or remove consent for telehealth service at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.
2. The state and federal laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is confidential, just as it would be if I were in the clinic. I understand that the visit is transmitted over dedicated lines and cannot be accessed by any unauthorized individuals.
3. I give my consent to be interviewed by the consulting healthcare provider. I also understand that other individuals may be present to operate the video equipment and that they will be held to the same standard of confidentiality for any/all information obtained.
4. I agree that certain situations including emergencies and crises are inappropriate for audio / video / computer-based psychotherapy services. If I am in crisis or in an emergency I should immediately call 911 or go to the nearest hospital or crisis facility. By signing this document, I acknowledge that I have been told that if I feel suicidal I am to call 911, local county crisis agencies or the National Suicide Hotline at 1-800-784-2433.
5. I understand that a limited examination may take place during the telephonic or video conference and that I have the right to ask my healthcare provider to discontinue the conference at any time. I understand that some parts of the exam may be conducted by individuals at my location at the direction of the consulting healthcare provider.
6. I understand that there may be technological issues such as interruptions or difficulties which may occur. Due to this, my healthcare provider or I can discontinue the telehealth consult/visit if it is felt that the audio / video tele-conferencing connections are not adequate for the situation.
7. I understand that billing will occur from the healthcare provider and facility based on the telehealth services provided.

I have read this document and understand the risk and benefits of telehealth services and have had my questions regarding the services explained. I hereby consent to participate in a telehealth visit under the conditions described in this document.

Print Patient Name: _____ **DOB: _____**

Patient Signature: _____ **Date: _____**

Parent / Guardian Signature (if under 18): _____ **Date: _____**

Office Use Only:
In lieu of the required written consent or beneficiary signatures, verbal permission was requested and received prior to initiating the telehealth visit having covered all the items in the Informed Consent.
Verbal consent given by: _____Date:_____
Employee Name: _____Date:_____

Revised: 12/26/2023; Revised 06/25/2024
Created On: 3/30/2020