Kentucky Mountain Health Alliance, Inc.

New / Updated Patient Assessment

Patient Name: ______________________ Phone: (____) ____-______ Date: ____/____/____
Address: ______________________ City: ____________ State: ____ Zip: ________
SS#: ______-________-________ Date of Birth: _____/_____/_____ Age: __________

If patient is a minor, please fill out guardian information below!!!

Guardian Name: ______________________ Date of Birth: ___/___/___ Social Security #: ____-___-____

PLEASE FILL ALL INFORMATION OUT

Gender: _____Female _____Male _____Trans (Female to Male) _____Trans (Male to Female) _____Gender Queer _____Decline to Answer _____Other

Sexual Orientation: _____ Straight _____Lesbian or Gay ____ Bisexual ____Something Else _____ Do Not Know _____ Decline to Answer

Race: _____Asian _____Native Hawaiian _____Black/African American _____American Indian _____White _____More than once Race _____Unreported

Ethnicity: Hispanic/Latino ___Yes ___No | US Veteran: ___Yes ___No | Tobacco Use: ___Yes ___No

Language: _____ English _____ Spanish _____ Other | Marital Status: ____Married ____Divorced ____Single

MEDICAL HOME

Are you receiving services from any other healthcare/mental health agency? _____Yes _____No
If yes, please list agency: ______________________ Contact Name: ______________________

INSURANCE

☐None (Self-Pay) ☐Medicaid: ______________________ ☐Medicare: ______________________
☐Commercial: ______________________ ☐Private: ______________________

RESPONSIBLE PARTY (If different from patient)

Name: ______________________ Relationship to Patient: ______________________
Address: ______________________ City: __________ State: ________ Zip: __________

EMPLOYMENT STATUS (Please Check One)

Full Time: ____________ Part Time: ____________ Retired: ____________
Disable: ____________ Not Employed: ____________

HOUSEHOLD INCOME (To determine eligibility for our Sliding Fee Scale, even if you have insurance)

Source (SSI, Wages, Food Stamps, Retirement, etc.) | Monthly $ ____________ | Annually $ ____________

Number in Household: ____________

Patient Signature: ______________________ Date: ____________
Witness Signature: ______________________ Date: ____________

KENTUCKY MOUNTAIN HEALTH ALLIANCE, INC
HOUSING ASSESSSMENT

Name: ______________________________ **Birthdate:** ________________

In March 1999, the Bureau of Primary Health Care stated that a homeless person is: *An individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation. An individual may be considered homeless if that person is 'doubled up,' a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family members. In addition, previously homeless individuals who are to be released from a prison or a hospital may be considered homeless if they do not have a stable housing situation to which they can return. A recognition of the instability of an individual's living arrangement is critical to the definition of homelessness.*

Check all that apply.

CATEGORY 1: Individual without permanent housing.

_____Emergency or Transitional Shelter
_____Transitional Housing
_____Single Room Occupancy Shelter
_____Streets, under bridges, caves, cars, abandon building, shed, barn, tent, camper, trailer, or other that is not fit for human habitation
_____Within one week of being evicted
_____Living in a house, trailer, or other structure that is not fit for human habitation.
The house must be dilapidated and meet one of the following:

1. Doesn't have operable indoor plumbing.
2. Doesn't have usable flushing toilet inside.
3. Doesn't have usable bathtub or shower inside.
4. Doesn't have adequate or safe electrical service.
5. Doesn't have adequate or safe heat service.

CATEGORY 2: Individual who is 'doubled up,' or in a situation where they are unable to maintain their housing situation.

_____Living from place to place
_____Living with family or friends because you don't have a choice
_____Families where the member are separated into different houses (son with aunt, daughter with grandmother, and the parent Whenever she/he can)
_____Living in overcrowded situations (more than two people per bedroom)
_____Staying with people in public housing or other settings that restrict the number and nights that tenants may have overnight guest.

CATEGORY 3: Individual who was released from a prison or treatment facility that was previously homeless <u>and</u> who does not have a stable housing situation to which they can return.

_____Discharge from healthcare facility, mental health facility, rehabilitation, or correction program.

CATEGORY 4: Individual living in unstable situation. Factors to consider:

_____Imminent risk of foreclosure/eviction due to economic reasons. Reasons may include termination from employment, Unexpected medical costs, inability to maintain housing costs including utilities, etc.
_____In an abusive or dangerous relationship. Intimate partner violence, family/friends taking advantage of a person with a Disability or who is elderly or any violent situation.
_____Spending more than 50% of income toward rent/mortgage and utilities.

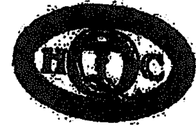
This is to certify the above individual is homeless or currently at risk of homelessness based on the category checked.

Patient Signature: ______________________________ **Date:** ______________

Witness Signature: ______________________________ **Date:** ______________

Release and Permission Form

Kentucky Mountain Health Alliance, Inc.



I, ______________________________ (Client Name) do authorize the Kentucky Mountain Health Alliance, Inc. to release information on my behalf, I also give KMHA, permission to act as a liaison between my physicians, nurse, office staff, indigent pharmaceutical company, and local community, and local community resources, on my behalf.

I understand by signing the form that I have given KMHA permission to provide services and to access any medical and social needs that I might have. I also understand that KMHA will enter my information into the KMHA database and may use my medical or financial information from my records to assist me in this process.

This content may be revoked at any time, except to the extent that action has already been taken by the client/duly authorized agent and will expire automatically in one year from the date below.

Description	YES	NO
May we leave information regarding your access issues, appointments, diagnosis, treatment and follow-up on your answering machine? (Client must provide phone number.)(_____)_____-_____		
May we communicate information regarding your access issues, appointments, diagnosis, treatment and follow-up through email? (Client must provide email address.)_______________@________		

We may discuss your access issues, appointments, diagnosis, treatment and follow-up with the family member(s) and / or care giver(s) listed below.

(Please note that the client may choose some of the information or to not let any of the above be discussed.)

____
Name (Please Print) (_____)____________ Phone

____
Name (Please Print) (_____)____________ Phone

(This authorization applies to Kentucky Mountain Health Alliance, Inc. only and will remain in effect until I give a written notice to revoke it.)

____
Signature of Patient _____/_____/_____ Date

____
Signature of Employee/KMHA _____/_____/_____ Date

Note to Staff: This form does not constitute an authorization for release of written information. Only authorized personnel may release written information pursuant to KMHA policies.

(Revised: 07/24/2023)

Kentucky Mountain Health Alliance, Inc.

CONSENT TO TREATMENT FORM

I voluntarily authorize the rendering of such care, including diagnostic procedures, medical treatment, mental health/substance abuse services and dental treatment by authorized agents and employees of the Kentucky Mountain Health Alliance, Inc., and its medical staff, or their designees, as may in their professional judgement be deemed necessary or beneficial, and may include testing for HIV (the virus that causes AIDS) and other blood borne diseases. I acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition. I understand that I have the right to make decisions concerning my health care or the health care of the person for whom I am duly authorized to make such decisions, including the right to refuse medical and surgical procedures.

Patient Name (Print): ____

Date: ____________________ Patient Signature: ____________________________

If patient is a minor OR unable to sign: Legal Guardian, Next of Kin, or Legal Agent can sign below:

Signature: ____

If patient is unable to sign, secure consent of Next of Kin or Legal Agent and indicate reason below:

( ) Minor
( ) Medically Unstable
( ) Disoriented
( ) Incompetent

Witness Signature (Employee Signature) : ________________________________

(Revised 07/24/2023)

Kentucky Mountain Health Alliance, Inc.

What You Need to Know About HIV and AIDS

While there have been great strides in the prevention of HIV transmission and care of HIV infection and AIDS since AIDS was first recognized in 1981, many people still have questions about HIV and AIDS. The information below is designed to answer some of these questions based on the best available science.

What are HIV and AIDS?

HIV is the human Immunodeficiency virus. It is the virus that can lead to acquired immune deficiency syndrome, or AIDS. CDC estimates that about 56,000 people in the United States contracted HIV in 2006.

There are two types of HIV, HIV-1 and HIV-2 in the United States, unless otherwise noted, the term "HIV" primarily refers to HIV-1.

Both types of HIV damage a person's body by destroying specific blood cells, called CD4+ T cells, which are crucial to helping the body fight diseases.

Within a few weeks of being infected with HIV, some people develop flu-like symptoms that last for a week or two, but others have no symptoms at all. People living with HIV may appear and feel healthy for several years. However, even if they feel healthy, HIV is still affecting their bodies. All people with HIV should be seen on a regular basis by a health care provider experienced with treating HIV infection. Many people with HIV, including those who feel healthy, can benefit greatly from current medications used to treat HIV infection. These medications can limit or slow down the destruction of the immune system, improve the health of people living with HIV, and may reduce their ability to transmit HIV. Untreated early HIV infection is also associated with many diseases including cardiovascular disease, kidney disease, liver disease, cancer. Support services are also available to many people with HIV. These services can help people cope with their diagnosis, reduce risk behavior, and find needed services.

AIDS is the late stage of HIV infection, when a person's immune system is severely damaged and has difficulty fighting diseases and certain cancers. Before the development of certain medications, people with HIV could progress to AIDS in just a few years. Currently, people can live much longer- even decades – with HIV before they develop AIDS. This is because of "highly active" combinations of medications that were introduced in the mid 1990's.

No one should become complacent about HIV and AIDS. While current medications can dramatically improve the health of people living with HIV and slow progression from HIV infection to AIDS, existing treatments need to be taken daily for the rest of a person's life, need to be carefully monitored, and come with costs and potential side effects. At this time, there is no cure for HIV infection. Despite major advances in diagnosing and treating HIV infection, in 2007, 35,962 cases of AIDS were diagnosed and 14,110 deaths among people living with HIV were reported in the United States.

HIV is spread primarily by:

- Not using a condom when having sex with a person who has HIV. All unprotected sex with someone who has HIV contains some risk.
  - Unprotected anal sex is riskier than unprotected vaginal sex.
  - Among men who have sex with other men, unprotected receptive anal sex is riskier than unprotected insertive anal sex.
- Having multiple sex partners or the presence of other sexually transmitted diseases (STDs) can increase the risk of infection during sex. Unprotected oral sex can also be a risk for HIV transmission, but it is a much lower risk than anal or vaginal sex.
- Sharing needles, syringes, rinse water, or other equipment used to prepare illicit drugs for injection.
- Being born to an infected mother – HIV can be passed from mother to child during pregnancy, birth, or breast-feeding.

Less common modes of transmission include:

- Being "stuck" with an HIV-contaminated needle or other sharp object. This risk pertains mainly to healthcare workers.
- Receiving blood transfusions, blood products, or organ/tissue transplants that are contaminated with HIV. This risk is extremely remote due to the rigorous testing of the U.S. blood supply and donated organs/tissue.
- HIV may also be transmitted through unsafe or unsanitary injections or other medical or dental practices. However, the risk is also remote with current safety standards in the U.S.
- Eating food that has been pre-chewed by an HIV-infected person. The contamination occurs when infected blood from a caregiver's mouth mixes with food while chewing. This appears to be a rare occurrence and has only been documented among infants whose caregiver gave them pre-chewed food.
- Being bitten by a person with HIV. Each of the very small number of cases has included severe trauma with extensive tissue damage and the presence of blood. There is no risk of transmission if the skin is not broken.
- Contact between broken skin, wounds, or mucous membranes and HIV-infected blood or blood-contaminated body fluids. These reports also been extremely rare.
- There is an extremely remote chance that HIV could be transmitted during "French" or deep, open-mouth kissing with an HIV-infected person if the HIV-infected person's mouth or gums are bleeding.
- Tattooing or body piercing present a potential risk of HIV transmission, but no cases of HIV transmission from these activities have been documented. Only sterile equipment should be used for tattooing or body piercing.
- There have been a few documented cases in Europe and North Africa where infants have been infected by unsafe injections and then transmitted HIV to their mothers through breastfeeding. There have been no documented cases of this mode of transmission in the U.S.

HIV cannot reproduce outside the human body. It <u>is not</u> spread by:

- Air or water.
- Insects, including mosquitoes. Studies conducted by CDC researchers and other have shown no evidence of HIV transmission from insects.
- Saliva, tears, or sweat. There is no documented case of HIV being transmitted by spitting.
- Casual contact like shaking hands or sharing dishes.
- Closed-mouth or "social" kissing.

All reported cases suggesting new or potentially unknown routes of transmission are thoroughly investigated by state and local health departments with assistance, guidance, and laboratory support from CDC.

If you would like more information or have personal concerns, call **CDC-INFO 8A-8P (EST) M-F. Closed weekends and major federal holidays at 1-800-CDC-INFO (232-4636), 1-888-232-6348 (TTY), In English, en Español**

By signing this form you are consenting to be tested for HIV.

Patient Name (Please Print): ______________________________ Date: ________________

Patient Signature: ______________________________ Employee Signature: ________________

(Revised 08/03/2023)

Kentucky Mountain Health Alliance, Inc.

Consent to the Use and Disclosure of health Information for Treatment, Payment, or Healthcare Operation

HIPAA Consent Form

I, ______________________________, understand that as part of my health care, Kentucky Mountain Health Alliance, Inc., originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans or future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment ,
- A means of communication among the many health professional who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that service billed were actually provided, and
- A tool For routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges.

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Kentucky Mountain Health Alliance, Inc., is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 164.506 of the Code of Federal Regulations.

I further understand that Kentucky Mountain Health Alliance, Inc., reserves the right to change their notice and practices and prior to implementation, in accordance with section 164.520 of code of Federal Regulations. Should Kentucky Mountain Health Alliance, Inc., change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).I wish to have the following restrictions to the use or disclosure of my health information:

____

I understand that as a part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent. I have received a notice of Privacy Practices.

Patients Name (Please Print): ______________________________
Patient, Parent, or Guardian

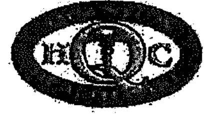
Patients Signature: ______________________________

Date: ______________________________

FOR OFFICE USE ONLY
[ ] Consent received by (Employee Signature): ______________________________on Date: ____________________

(Revised 07/24/2023)

KENTUCKY MOUNTAIN HEALTH ALLIANCE, INC.
HEALTHCARE FOR THE HOMELESS
PATIENT RIGHTS AND RESPONSIBILITIES



The following "Patient Rights and Responsibilities" statement and the "Patient Grievance" statement will be posted in the clinic's lobby.

YOUR RIGHTS AS A PATIENT

1. You have the right to the appropriate medical treatment as available and medically indicated.
2. You have the right to considerate, respectful care.
3. You have the right to privacy concerning your treatment and to confidentiality regarding the records of your medical care.
4. You have the right to discuss your illness and its treatment with your doctor.
5. You have the right to participate in decisions involving your healthcare.
6. You have the right to refuse treatment to the extent permitted by law.
7. You have the right to know what clinic rules apply to you and the right to share in your health care program.
8. You have the right to file a grievance if not satisfied with the services you receive.
9. You have the right to receive care regardless of race, color, sex, national origin, disability, religion, age, or sexual orientation.

YOUR RESPONSIBILITIES AS A PATIENT

1. You have the responsibility to provide as accurate and complete information as possible about past and present illness and medication.
2. You have the responsibility to follow the treatment plan for your care.
3. You are responsible for your actions if you refuse treatment or do not follow your doctor's instructions.
4. You are responsible for following clinic rules and regulations.
5. You are responsible for consideration and respect of other patients, clinic personnel and clinic property.

PATIENT GRIEVANCE

If you feel that you have been treated unfairly or if you are not satisfied with the services you have received in this clinic, please ask to speak with the clinic manager. If you want to leave your name, address, telephone number and complaint on a card or patient questionnaire, you may do so and place it in the box provided. If you want to speak to another representative, you may call the Kentucky Mountain Health Alliance, Inc., Administrator at 487-9505 or Quantum Healthcare Associates Administrator at 606-436-0711. Someone will contact you regarding your concerns.

MEDICAL PROVIDER RIGHTS

1. Kentucky Mountain Health Alliance, Inc. has medical personnel providing services to our patients who are volunteers, unpaid, and have not assumed the obligation to serve as the patient's primary care giver outside this clinic.
2. The patient will not contact the medical provider(s) at his or her office or indicate to anyone that the volunteer providers are the patient's primary care giver. However, you may contact Kentucky Mountain Health Alliance, Inc. for any questions pertaining to your care.
3. The patient will be treated by the medical provider(s) on duty at the Kentucky Mountain Health Alliance, Inc. on their appointment date. The patient waives the right to request a particular medical provider at the clinic.
4. Volunteer providers will be seen by appointment only.

ACKNOWLEDGEMENT OF PATIENT MEDICAL RIGHTS AND RESPONSIBILITIES

I hereby certify that I have read and/or had explained to me and understand the contents of the Patient's Rights and Responsibilities and the Medical Provider Rights and have voluntarily agreed to abide by these terms.

Date: ____________________

Patient Name (Please Print): ____

Patient Signature: ____

Employee Signature: ____

KENTUCKY MOUNTAIN HEALTH ALLIANCE, INC.

BOARD APPROVAL: 07/26/2023

Title: Sliding Fee Discount Policy

Revision: 9/4/2014
Review Date: 6/13/2018
Board Approval: 07/31/2019
Revision Date: 02/29/2020
Revision Date: 01/13/2021
Last Revision Date: 01/24/2022
Board Approval: 01/26/2022
Most Recent Board Approval: 03/14/2023

Purpose: To ensure that the Center provides services to all patients without regard to the patient's ability to pay. This sliding fee discount policy applies to all services and all patients.

Policy:

No patient will be denied services because of inability to pay. Patients will be expected to comply with the efforts of the Front Office Staff to ascertain the existence of any third-party insurance coverage a patient may possess, and/or to exhaust all other payment sources, or otherwise appropriately document the patient's ability to pay for services.

Patients lacking adequate third-party insurance coverage will be expected to provide appropriate information for the completion of a financial assessment. Based upon the proof of income presented, the patient will be informed of his/her eligibility for the Sliding Fee Program by the Front Office Team Staff, in person or via telephone. Individuals with Limited English Proficiency patients will be notified in accordance with Center's LEP Policy.

Please NOTE: If you have third-party insurance and are unable to pay your co-insurance (Medicare and/or commercial insurance that do not restrict discounts due to contractual or legal limitations) or deductible on non-covered services you may be eligible for our Sliding Scale Program and/or make a payment arrangement with our billing clerk. Underinsured patients will be determined by examining the patient's proof of income in comparison to their deductible/coinsurance. Proper proof of income is the most current tax return, the most recent paystubs, most recent statement from social services (such as an Award Letter), or a letter from the caregiver with explicit amounts of money that are given on a monthly basis.

Discounts are offered to uninsured and underinsured patients based upon family/household size and annual income. Household size is determined by mother, father, and dependent children under 18. Other adults in the household, even though related, are not included. Income includes: earnings, unemployment compensation, worker's compensation, social security, supplemental security income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Noncash benefits (such as food

stamps and housing subsidies) do not count.

Sliding scale discounts will be based on the most recent Federal Poverty Index guidelines as indicated in the scale below.

2023 SLIDING FEE SCALE
(Based on Annual Income)

Federal Poverty Guideline	At or Below 100% FPG	101% - 125% FPG	126% - 150% FPG	151% - 175% FPG	176% - 200% FPG	Above 200% FPG
Family Size	**Level I $0**	**Level II $10**	**Level III $25**	**Level IV $35**	**Level V $50**	**Level VI (No Discount)**
1	$0 - $14,580	$14,581 - $18,225	$18,226 - $21,870	$21,871 - $25,515	$25,516 - $29,160	$29,161+
2	$0 - $19,720	$19,721 - $24,650	$24,651 - $29,580	$29,581 - $34,510	$34,511 - $39,440	$39,441+
3	$0 - $24,860	$24,861 - $31,075	$31,076 - $37,290	$37,291 - $43,505	$43,506 - $49,720	$49,721+
4	$0 - $30,000	$30,001 - $37,500	$37,501 - $45,000	$45,001 - $52,500	$52,501 - $60,000	$60,001+
5	$0 - $35,140	$35,141 - $43,925	$43,926 - $52,710	$52,711 - $61,495	$61,496 - $70,280	$70,281+
6	$0 - $40,280	$40,281 - $50,350	$50,351 - $60,420	$60,421 - $70,490	$70,491 - $80,560	$80,561+
7	$0 - $45,420	$45,421 - $56,775	$56,776 - $68,130	$68,131 - $79,485	$79,486 - $90,840	$90,841+
8	$0 - $50,560	$50,561 - $63,200	$63,201 - $75,840	$75,841 - $88,480	$88,481 - $101,120	$101,121+

For Families with more than 8 members, add $5140 for each additional member

All sliding fee levels will receive a 100% discount of charge with a nominal fee or discounted rate as outlined below. Persons over 200% of FPG will be responsible for the full charge and receive no discount**.

****Any *patients paying in full at the time of service will receive a 35% discount on services rendered. This discount will be in addition to the Sliding Fee Scale Discount for patients that qualify.***

Patients qualifying for a sliding scale discount will be expected to pay a nominal (flat) fee for Level I and a discounted rate for Level II-IV based on our sliding fee scale at the time services are rendered. This payment will cover all charges incurred as part of a single visit, including ancillary services such as those received from laboratory and injections. Charges for all services rendered are to be recognized at their full value within the KMHA fee schedule and fully discounted apart from the applicable flat fee established for the services.

Applicability: This policy applies to all patients and all services offered at the clinic. No patient will be denied services regardless of inability to pay.

	Nominal Fee	Discounted Rate				
	Level I	Level II	Level III	Level IV	Level V	Level VI
340B Pharmacy Drugs	$0	340B price of drugs only	340B price of drugs plus 25% of dispensing and admin fees.	340B price of drugs plus 50% of dispensing and admin fees.	340B price of drugs plus 75% of dispensing and admin fees.	Full Fee Patient pays 340b cost of the drug and 100% of fees
Medical	$0	$10	$25	$35	$50	Full Fee, unless paying in full on day of service
Behavioral Health	$0	$10	$25	$35	$50	Full Fee, unless paying in full on day of service
Dental (Preventative)	$50	$60	$75	$85	$100	Full Fee, unless paying in full on day of service
Dental (Dentures/Partials) (Crowns/Bridges)	$400 Full Set Dentures or $300 Per Partial + Applicable Level Charges					
	$400 Per Unit on Bridges and $400 Per Unit on Crowns					
	100% FPG or below would pay $400 + $50 = $450					
	101-125% FPG would pay $400 +$60 = $460					
	126-150% FPG would pay $400 + $75 = $475					
	151-175% FPG would pay $400 + $85 = $485					
	176-200% FPG would pay $400 + $100 = $500					
Root Canal	Applicable Level Charges per Visit for a total of 3 visits					
Nominal Fee was determined by assessing the collection rates by discount pay class, write-off rates by discount pay class, patient surveys and board input.						
Patients who are over the 200% FPG will be responsible for the fully loaded 340B cost (cost of medication + Administrative Fee + Dispense Fee)						

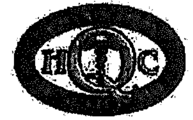
Patients lacking proper proof of income at the initial visit must provide this documentation within sixty (60) business days or the Sliding Scale Program eligibility provision will be cancelled. Should this action occur, the patient will then be placed in the full-pay (100%) category until income verification is provided unless other arrangements have been approved by the registration supervisor. Final determination of the eligibility and proof of income documents will be signed and reviewed by the Registration Staff.

When determining the Master Fee Schedule KMHA will utilize the Optum 360 Custom Fee Analyzer. The Master Fee Schedule will be reviewed annually and approved by the Board of Directors. Nominal fees for the sliding fee scale will be determined by the HCH Advisory Committee as well as the Board of Directors annually. Information used in making this determination will be obtained from assessments of patient income levels, insurance status, percentage of population below the Federal Poverty Line, and comparisons to other area FQHC HCH Programs. In addition to this, annual reviews of historic Self Pay AR Reports will be analyzed in order to identify any barriers that may be present regarding patient's ability to pay nominal fee amount.

Patient Signature: ______________________________

Kentucky Mountain Health Alliance, Inc.

Telemedicine Informed Consent Form



Patient Name (Please Print): ______________________ **DOB:** ______________

You are going to have a clinical encounter using videoconferencing technology. You will be able to see and hear the provider and they will be able to see and hear you, just as if you were in the same room. Since 1994, the technology has connected tens of thousands of patients and providers in Kentucky. The information may be used for diagnosis, therapy, and follow-up and/or education.

Expected Benefits:

- Improved access to care by enabling a patient to remain within the facility and obtain services from providers at distant sites.
- Patient remains closer to home where local healthcare providers can maintain continuity of care.
- Reduced need to travel for the patient or other provider.

The Process:

You will be introduced to the provider and anyone else who is in the room with the provider. You may ask questions of the provider or nay telemedicine staff in the room with you. If you are unsure of what is happening. If you are not comfortable with seeing a provider on videoconference technology, you may reject the use of the technology and schedule a traditional face-to-face encounter at any time. Safety measures are being implemented to ensure that this videoconference is secure, and no part of the encounter will be recorded without your written consent.

Possible Risks:

There are potential risks associated with the use of telemedicine which include, but may not be limited to:

- A provider may determine that the telemedicine encounter is not yielding sufficient information to make an appropriate clinical decision.
- Technology problems may delay medical evaluation and treatment for today's encounter.
- In very rare instances, security protocols could fail, causing breach of privacy of personal medical information.

By Signing this Form, I understand the following:

1. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that if the provider believes I would be better served by a traditional face-to-face encounter, they may, at any time stop the telehealth visit and schedule a face-to-face visit.
4. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
5. I agree that I am responsible to Kentucky Mountain Health Alliance, Inc. and any other facility or provider that is providing services through telehealth, contracting with KMHA, for charges resulting from the services rendered using videoconferencing technology at their prevailing rates.
6. I further understand that I am free to withdraw my consent at any time, and in doing so, will turn in a written revocation to KMHA at that time.

Patient Consent to the Use of Telemedicine

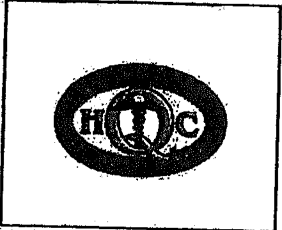
I have read and understand the information provided above regarding telemedicine, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my care.

Signature of Patient (or authorized Person): ______________________________

Date: ______________________________

Employee Signature: ______________________________

Kentucky Mountain Health Alliance, Inc.
Patient Centered Medical Home
Compact Agreement



Welcome and thank you for choosing Kentucky Mountain Health Alliance, Inc. We are committed to providing you with the best medical care based on your health needs. KMHA's hope is that we can form a partnership with you to keep your whole self as healthy as possible, no matter what your current state of health is.

Your commitment to our patient-centered medical home clinic will provide you with an expanded type of care. We will work with both you and other health care providers as a team to take care of you. You will also have better access to our providers through phone and the secure KMHA's patient portal.

As your primary care provider we will:

- Learn about you, your family, life situation, and health goals and preferences. We will remember these and your health history every time you seek care and suggest treatments that make sense to you.
- Take care of short term illness, long term chronic disease, and your all-around wellbeing.
- Keep you up to date on all your vaccines and preventive screening tests.
- Connect you with other members of your care team (specialists, health coaches, etc.) and coordinate your care with them as your health needs change.
- Be available to you after hours for your urgent needs.
- Notify you of test results in a timely manner.
- Communicate clearly with you so you understand your condition(s) and all your options
- Listen to your questions and feelings. KMHA's will respond promptly to you in a way you understand.
- Help make the best decisions for your care utilizing education resources and current literature that relate to your health issue(s).
- Give you information about classes, support groups, or other services that can help you learn more about your condition and stay healthy.
- Request all related healthcare information about you from other physicians/specialist/facilities.

We trust you, as our patient to:

- Know that you are a full partner in your care.
- Come to each visit with any updates on medications, dietary supplements, or remedies you're using and questions you may have.
- Keep scheduled appointments or call to reschedule or cancel as early as possible.
- Understand your health condition, as questions about your care, and tell us when you don't understand something.
- Learn about your condition(s) and what you can do to stay as healthy as possible.
- Follow the plan that we have agreed is best for your health.
- Take medications as prescribed.
- Call if you do not receive your test results within 2 weeks.
- Contact us after hours only if your issue cannot wait until the next day.
- If possible, contact us before going to the emergency room so someone who know your medical history can care for you.
- Agree that all health care providers in your care team will receive all information related to your health care.
- Learn about health insurance coverage and contact KMHA if you have questions about your benefits.
- Pay your share of any fees.
- Give us feedback to improve our care for you.

We look forward to working with you as your primary care provider in your patient-centered medical home.

Patient Name (Please Print): ______________________________ Date: ____________________

Patient Signature: ____

Employee Signature: ____