Welcome to Hunter Health!

We are happy you picked Hunter Health to take care of your health. We want to work with you to provide comprehensive care for your body, mind, and spirit.

At Hunter Health, we exist to improve the health and well-being of *everyone* in our community. We strive to provide a heartfelt, team-based care approach to the whole person. We do this by taking a Patient-Centered Medical Home (PCMH) approach. PCMH is a type of healthcare that:

- ✓ Encourages you to work together with your care team
- ✓ Gives you easy access to coordinated, comprehensive, evidance-based care
- ✓ Ensures all of your preventive, acute, and chronic care needs are met
- ✓ Focuses on giving you care quickly and on time

Appointments:
We have three locations: Central Clinic at 527 N. Grove St., HumanKind at 935 N. Market St., and Brookside at 2750 S. Roosevelt St. The clinics are open Monday through Friday. There are extended hours and same-day appointments available. If you need help scheduling an appointment or selecting a care team, please call 316.262.2415 to speak with a patient services representative.

After-Hours Contact Information:
As your medical home, we want to help meet your healthcare needs even when our offices are closed. If you need to reach us after hours, please call 316.262.2415.

Your Role as the Most Important Member of Your Care Team:
Here are some things you can do to help us take care of you:

- ✓ Tell us about your medical history during your initial visit
- ✓ Do not hesitate to ask us questions if you do not understand something
- ✓ Be open and honest about your experience with us
- ✓ Bring your medications (or a written list of them) to every visit
- ✓ Arrive to all of your appointments on time
- ✓ Work with us to set goals to manage your chronic conditions

Thank you for choosing Hunter Health. We are excited to work with you on your healthcare goals.

Sincerely,

Caitlin Chiles MD

Dr. Caitlin Chiles, MD
Director of Primary Care

Patient Account Number_____

HUNTER HEALTH

PATIENT REGISTRATION FORM

Last Name:_____ Middle Initial:_____ First Name: _____

Suffix:_____ Preferred Name:_____

Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence. If your preferred name is different from these, please let us know.

Address:_____City:_____State:_____Zip Code:_____

Home Phone:_____Cell Phone:_____

Social Security Number (SSN):_____Date of Birth:_____

DEMOGRAPHIC INFORMATION

Marital Status: □ Single □ Married □ Partnered □ Divorced □ Separated □Widowed

Preferred Language: □ English □ Spanish □ Vietnamese □ Other: _____

Do you need a translator? □ Yes □ No

Ethnicity: □ Not Hispanic or Latino □ Mexican, Mexican American, Chicano/a □ Puerto Rican □ Cuban
□ Other Hispanic Latino or Spanish-Origin □ Choose not to disclose

Race: *(Check all that apply)*

□ Asian Indian □ Chinese □ Filipino □ Japanese □ Korean □ Vietnamese □ Other Asian

□ Native Hawaiian □ Guamanian or Chamorro □ Samoan □ Other Pacific Islander □ Black/African American

□ American Indian or Alaska Native □ White □ Choose not to disclose

Birth Sex/Assigned Sex at Birth: □ Male □ Female

*Sexual Orientation: *(Not required if under the age of 18.)*

- □ Straight (Not Lesbian or Gay), or Heterosexual
- □ Lesbian, Gay, or Homosexual
- □ Bisexual
- □ Other_____
- □ Unsure
- □ Choose not to disclose

*Gender identity: I currently identify as:

- □ Male
- □ Female
- □ Transgender Male (Female to Male)
- □ Transgender Female (Male to Female)
- □ Other_____
- □ Choose not to disclose

Sexual orientation and gender identity can play a significant role in determining health outcomes. Please see the front desk or ask your healthcare team if you have questions about disclosing this information.

Patient Account Number_____

THE FOLLOWING QUESTIONS ASK ABOUT INDIVIDUALS THAT HUNTER HEALTH IS DEDICATED TO SERVING.

Are you currently experiencing homelessness? □ Yes □ No

If yes, are you using any of the following? □ Homeless shelter □ Transitional housing □ Staying with a friend/family

□ On the street □ Permanent supportive housing □ Other, please specify:_____

Please indicate if you belong to any of these groups: □ Seasonal Farm Worker □ Migrant Farm Worker

□ Other Farm Worker □ Veteran of U.S. Uniformed Services □ Active in U.S. Uniformed Services □ Does Not Apply

INCOME & EMPLOYMENT INFORMATION

Occupation:_____□ Full Time □ Part Time

Employer:_____Work Phone: _____

Number in Household:_____Total Household Income:_____□ Per Year □ Monthly □ Bi-Weekly □ Weekly

INSURANCE INFORMATION

Please enter your primary insurance information.

□ I do not have health insurance

Insurance Name: _____ Insurance Policy Number #: _____

Policy Holder Name: _____ Policy Holder Date of Birth:_____

Policy Holder Social Security Number (SSN): _____

Patient relationship to insured: □ Self □ Spouse □ Child □ Other_____

Do you have more than one insurance? □ Yes □ No

If you have additional insurance, please enter that information here.

Name: _____ Insurance Policy Number #: _____

Policy Holder Name: _____ Policy Holder Date of Birth:_____

Policy Holder Social Security Number (SSN): _____

Patient relationship to insured: □ Self □ Spouse □ Child □ Other_____

IF PATIENT IS UNDER AGE 18

Legal Guardian:_____Relationship to Patient:_____

Father's Name:_____ Father's Employer:_____ Phone: _____

Mother's Name:_____ Mother's Employer:_____Phone:_____

PLEASE HAVE THE FOLLOWING DOCUMENTS READY

□ Photo ID □ Proof of Income □ Insurance Card □ Tribal Identification/Verification (if applicable)

Patient Account Number_____

IN CASE OF EMERGENCY

Who should we contact?

First Name: _____Last Name: _____Relationship:_____

Street Address:_____City_____ State_____Zip Code_____Primary Phone:_____

NEXT OF KIN

First Name: _____Last Name: _____

Relationship:_____ Street Address:_____

City_____State_____Zip Code_____Primary Phone:_____

HOW DID YOU HEAR ABOUT US?

☐ Friend/Family member ☐ Social Media (e.g., health fair, festival) ☐ Flyer/Poster in the neighborhood ☐ Radio/TV advertisement

☐ Internet search (e.g., Google) ☐ Referral from another healthcare provider ☐ Local newspaper/magazine

☐ Community organization or church ☐ Other (please specify):_____

HUNTER HEALTH

CONSENT TO COMMUNICATE

USE OF PHONE CALLS, TEXT MESSAGING, AND THE PATIENT PORTAL

Automated phone calls and text messages allow our healthcare providers to communicate with you regarding appointments, when new lab results are available, and other general information for your convenience. At the same time, we recognize that text messaging is not a completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly while in storage or during transmission.

We recommend that our patients over the age of 18 sign up for our patient portal, Healow, which allows secure communication with your care team and access to your health information at your convenience.

If you would like to utilize automated voice messages, to send you text messages, and/or to sign up for the patient portal, please check the appropriate boxes and sign this consent below. You are not required to authorize the use of patient portal, text messaging, or automated voice messages. A decision not to sign this authorization will not affect your healthcare in any way. You may change your mind at any time by informing a staff member. If you prefer not to authorize the use of automated voice messages and/or text messaging, we will continue to use U.S. Mail or telephone to communicate with you.

I authorize the use of the following communication methods when communicating with me (check all that apply):

☐ I would like to enroll in the **patient portal** with the following email address:

_____

☐ I would like to receive **text messages** at the following mobile number:_____

☐ I would like to receive **automated voice messages** at the following number:_____

Please note: Patient Portal access for parents or guardians of minor patients will have limited access to protected health information in accordance with state and federal regulations

Signature of Patient/Personal Representative Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

Printed name of Patient/Personal Representative Relationship to Patient

HUNTER HEALTH

CONSENT TO TREAT

GENERAL CONSENT

Hunter Health is dedicated to providing comprehensive primary care, dental, and behavioral health services. Because wellness involves both the body and mind, our team of providers work together to offer you high quality whole person healthcare. Your providers may involve other healthcare specialists as part of your care team. Members of your healthcare team will collaborate and share clinical information for continuity of care.

I consent to and authorize testing, treatment and care by nurses, employees, and others as ordered by my healthcare provider, or as directed pursuant to standing medical orders or protocols. I also understand that individuals in professional training programs may be among the individuals who provide care to me. I understand that in connection with my treatment, photos or video may be taken. Any tissue or body parts removed from my body may be retained or disposed of by Hunter Health at its sole discretion.

COMMUNICABLE DISEASE TESTING

I acknowledge that Kansas law provides if any healthcare worker is exposed to my blood or other bodily fluid the facility may perform tests, without my consent, on my blood or other bodily fluid to determine the presence of hepatitis B, C, and HIV. I understand that such testing is necessary to protect those who will be caring for me while I am a patient at Hunter Health. I understand that the results of tests taken under these circumstances are confidential.

ASSIGNMENT OF BENEFITS

I request and authorize payment of authorized benefits be made on my behalf to Hunter Health for any services furnished to me by Hunter Health physicians and healthcare providers, and I assign my right to receive these payments to Hunter Health. I authorize Hunter Health to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided, and I authorize Hunter Health to release any information necessary for the purpose of determining coverage to my insurer or other entity responsible for claims payment without my further written consent.

FINANCIAL AGREEMENT

In consideration for the services rendered, I understand that I am financially obligated in accordance with Hunter Health's regular rates and terms regardless of whether insurance payments are available or made on my behalf. If my Health Insurance Plan will not direct payment to Hunter Health, I agree to forward to Hunter Health all health insurance payments, which I receive for the services rendered by Hunter Health and its health care providers. I understand that I am financially responsible for all charges which are not covered by insurance, including, but not limited to, co-pays, deductibles, charges in excess of policy coverage, and limitations or exclusions of coverage. I further agree that, if permissible by law, I will reimburse Hunter Health for all costs, expenses and attorney's fees that may be incurred by Hunter Health to collect those charges.

PATIENT NOTICES

I acknowledge that I have been given a copy of Hunter Health's Notice of Privacy Practices and Patient Rights and Responsibilities.

By signing this form, I agree that I have read or had this form read and/or explained to me, that I understand it, and any questions I asked have been answered.

Signature of Patient/Patient Representative Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

Printed name of Patient/Personal Representative Relationship to Patient

HUNTER HEALTH

FTCA NOTICE TO PATIENTS

NOTICE OF LIMITED LIABILITY FOR FTCA DEEMED FEDERALLY QUALIFIED HEALTH CENTERS

The Hunter Health Clinic, Inc., a Federally Qualified Health Center (FQHC), is deemed by the Bureau of Primary Health Care of the U.S. Department of Health and Human Services to be a federal employee for purposes of medical malpractice claims and, as such, qualified for protection under the Federal Tort Claims Act.

This health center receives U.S. Department of Health and Human Services (HHS) funding and has Federal Public Health Service (PHS) deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals.

This notice is required under federal law relating to the operation of Federally Qualified Health Centers, the Federal Tort Claims Act (FTCA) (See 28 U.S.C. §§ 1346(6), 2401(6), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions within the scope of deemed employment by any employee of a deemed health center who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. (See Public Health Service Act subsection 224(q), codified at 42 U.S.C. § 233(q)

The above Federal law and other State and Federal laws including the Federal Volunteer Protection Act of 1997 may cover certain Federally Qualified Health Center health care professionals providing health care services to patients at The Hunter Health Clinic, Inc.

Signature of Patient/Personal Representative Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

Printed name of Patient/Personal Representative Relationship to Patient

HUNTER HEALTH

NOTICE OF PRIVACY PRACTICES

Effective November 1, 2023

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

View or obtain a copy of your medical records. You can view or obtain a copy of the health information maintained by *Hunter Health Clinic*. If you request copies, we will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. While we may deny you access in certain limited circumstances, you may request review of that decision.

Ask us to correct your medical record. If you believe your records contain inaccurate or incomplete information, you may ask us to amend the information. To request an amendment, you must complete a specific form providing information we need to process your request, including the reason that supports your request. Except for certain exceptions, we will amend your file upon receiving a correct amendment request. We may say "no" to your request, but we will tell you why in writing, usually within 60 days.

Get a list of those with whom we've shared information. You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information provided that the information pertains solely to a health care item or service that has been paid to us in full. To request restrictions, you must complete a specific written form providing information we need to process your request.

Request confidential communications. You have the right to request that we communicate with you in a certain way or at a certain location. Forms are available to process that request. We will not ask you the reason for your request, and we will accommodate all reasonable requests.

Rights Relating to Electronic Health Information Exchange. *Hunter Health Clinic* participates in electronic health information technology or HIT. This technology allows a provider or a health plan to make a single request through a health information organization or HIO to obtain electronic records for a specific patient from other HIT participants for purposes of treatment, payment, or health care operations. HIOs are required to use appropriate safeguards to prevent unauthorized uses and disclosures.

You have two options with respect to HIT. First, you may permit authorized individuals to access your electronic health information through an HIO. If you choose this option, you do not have to do anything. Second, you may restrict access to all of your information through an HIO (except as required by law). If you wish to restrict access, you must submit the required information either online at http://www.KanHIT.org or by completing and mailing a form. This form is available at http://www.KanHIT.org. You cannot restrict access to certain information only; your choice is to permit or restrict access to all of your information.

If you have questions regarding HIT or HIOs, please visit http://www.KanHIT.org for additional information. If you receive health care services in a state other than Kansas, different rules may apply regarding restrictions on access to your electronic health information. Please communicate directly with your out-of-state health care provider regarding those rules.

Get a copy of this notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

To File a Complaint. If you feel your Privacy Rights have been violated, please contact Hunter Health's Patient Advocate at (316) 262-2415 to file a complaint. Our Privacy Officer will then review the details of your complaint and promptly notify you of the actions our office will take. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting http://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html. **We will not retaliate against you for filing a complaint.**

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Most marketing purposes
- Sale of your information
- Most sharing of your psychotherapy notes
- Substance abuse treatment records

You may revoke the sharing of the forgoing information at any time, provided that the revocation is in writing.

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

We typically use or share your health information in the following ways:

To treat you. We may use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

To run our organization. We may use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

To bill for your services. We may use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues:

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Research:
We can use or share your information for health research.

Comply with the law:
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Respond to organ and tissue donation requests:
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director:
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions:
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We are required by law to inform you if a breach occurs that may have compromised the privacy or security of your unsecured protected health information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

PRIVACY OFFICER CONTACT INFORMATION

Phone: 316-262-2415
E-mail: privacy@hunterhealth.org

HUNTER HEALTH

PERMISSION TO DISCLOSE

Individuals' Right under HIPAA to Access their Health Information 45 CFR § 164.524.

"The Privacy Rule generally requires HIPAA covered entities (health plans and most health care providers) to provide individuals, upon request, with access to the protected health information (PHI) about them in one or more "designated record sets" maintained by or for the covered entity. This includes the right to inspect or obtain a copy, or both, of the PHI, as well as to direct the covered entity to transmit a copy to a designated person or entity of the individual's choice."

Failure to provide all information requested may invalidate this request.

Patient Name		
Date of Birth		☐ Patient is a Minor

Notice: Requesting Medical Records (PHI) From Our Office

Our office requires patients and their representatives to sign this Access Form directing information disclosures or copies of medical records to other individuals involved in their care.

OPTION 1: ALL RECORDS WILL BE DISCLOSED

Please list all family members or other person(s), if any, whom we may disclose your protected health information, including treatment and payment information. These persons will have full access to your protected health information, are able to request copies of your medical records (PHI) and may also have full patient portal access of your records.

NAME	PHONE NUMBER	RELATIONSHIP

OPTION 2: LIMITED RECORDS WILL BE DISCLOSED

Please list all family members or other person(s), if any, whom we may disclose your protected health information, including treatment and payment information. These persons will NOT have full access to your PHI. Sexual Health Information allowed to be withheld by state law must be withheld as well as Mental Health and Drug Use protected by Disclosure of Substance Use Disorder Patient Records: Title 42 of the Code of Federal Regulations (CFR). These persons will have the ability to request medical records (PHI) but will not be given access to the patient portal as our office is unable to segment records in the portal.

NAME	PHONE NUMBER	RELATIONSHIP

- I hereby give my consent for Hunter Health to disclose protected health information (PHI) about me to the person or persons listed above in the manner described.
- I understand that, if the person or entity receiving the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations.
- I may revoke my consent at any time, but I must do so in writing and submit it to the following address: Hunter Health, 527 N. Grove, Wichita, KS 67214. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this request. This Access Form does not have an expiration date.

I have read and agree to all of the above.

Signature of Patient or Personal Representative **Date**

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

Print name of Personal Representative **Relationship to patient**

HUNTER HEALTH

RIGHTS AND RESPONSIBILITIES

Patient Rights

Patients can expect:

- To be treated with respect and dignity;
- To receive care in a clean, safe space that is free from abuse, neglect, or other mistreatment that could be used as a means of power, control, or revenge;
- To receive care without discrimination based on your race, color, religion, ancestry, national origin, age, sex, or genetics; sexual orientation or gender identity; marital, familial, disability, or veteran status; or any other protected status;
- To be communicated with in a language you can understand;
- To learn health information that is easy to understand, including your treatment options and their possible benefits and risks;
- To keep your health information private;
- To keep your treatment at Hunter Health private, including not fingerprinting, photographing, or recording you without your consent, except for organizational and security purposes;
- To help develop a personal treatment plan and make changes to that plan with your care team and provider;
- To refuse or remove permission for treatment unless treatment is ordered by a court or needed to save your life;
- To know the qualifications and names of all Hunter Health care team members and providers;
- To voice concerns about your care or experience and receive prompt follow-up about those concerns;
- To ask for and receive a copy of your bill and information on payment options, including our sliding fee discount and other available financial aid programs;
- To receive a written statement about your right to appeal if you are Alaskan Native/American Indian and are found ineligible for Indian Health Services;
- To receive a copy of these "Patient Rights and Responsibilities."

Patient Responsibilities

Patients are expected:

- To show up for appointments on time and give at least 24 hours notice if you need to reschedule;
- To give complete and correct information to the best of your ability about your identification, demographics, insurance, proof of income, and other legal documents (as needed);
- To give complete and correct information to the best of your ability about your present and past health conditions, medications, and treatments;
- To make sure all required forms are completed before the scheduled appointment starts;
- To actively participate in your medical care decisions and discussions with your provider and care team, including asking questions when you do not understand information;
- To follow your provider's treatment and referral advice to the best of your ability;
- To let your provider or other staff know about care-related concerns or complaints;
- To treat other patients, Hunter Health staff, and property with respect and consideration;
- To ensure privacy is maintained for myself and those around me by not using recording devices (audio or visual) while on Hunter Health property;
- To pay your bills from Hunter Health on time.