



Step 1: How did you hear about us?

- Social Media Radio Current Patient
- Employee Community Event Physician Referral
- Internet Search (Google, Bing, etc)
- Other: _____

Step 2: Complete Your Registration Paperwork. (Pages 7-12)

Fill out and sign all demographic and consent forms provided to you. If you need help, let us know.

Step 3: Complete Your Health History Forms (Pages 13-15)

Please ensure you provide accurate details, including surgeries, hospitalizations, medications, and allergies.

Step 4: Complete Release of Information Form. (Page 16)

This allows us to obtain records from your previous Primary Care Physician (PCP). If you have not seen a PCP before, please let us know.

Step 5: Bring All Completed Paperwork to Clinic;

Including:

- Photo ID
- Insurance Card(s)
- Proof of Income

Other items to bring if applicable:

- Native American Identification (CDIB or other)
- Guardianship / Power of Attorney

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, evidence-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,



Dr. Caitlin Chiles, MD
Director of Primary Care



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.



NOTICE OF PRIVACY PRACTICES

Effective February 16, 2026

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. We may deny you access in certain limited circumstances, although you may request a review of that decision.

Ask us to correct your medical records. If you believe your records contain inaccurate or incomplete information, you may ask us to make an amendment. 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 have 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, disclosures you requested, and certain other disclosures permitted by law. 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 communication. You have the right to request that we communicate with you in a certain way or at a certain location. An example would be asking that you only be contacted by us at work or only by mail, or you may prefer that we communicate with you via unencrypted email or text messaging. There are risks associated with communications via unencrypted email or text messaging, for example, a third party could intercept the email or text message in transmission. 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 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 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, you may file a complaint with us using the information on page 4. 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 cannot 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

You may revoke the sharing of the foregoing 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 may use and disclose your health information for these purposes without your written authorization, as permitted by law:

Treat you. We can 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.*

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

Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give your health insurance plan information 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 must 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

Contact Information. We may use and disclose your contact information (landline or cellular phone numbers, email

address). Some examples of how we may use your contact information include appointment reminders and to provide you with notification of other health-related benefits and services, all of which are discussed in more detail below. By providing us with your contact information, you give your consent that we may use it. We may contact you by the following means (even if we initiate contact using an automated telephone dialing system (ATDS) and/or an artificial or prerecorded voice): (1) paging system; (2) cellular telephone service; (3) landline; (4) text message; (5) email message; or (6) facsimile. For your convenience, email and text messages may be sent unencrypted. Before using or agreeing to use of any unsecure electronic communication to communicate with us, note that there are certain risks, such as interception by others, misaddressed/misdirected messages, shared accounts, messages forwarded to others, or messages stored on unsecured portable electronic devices. If you want to limit these communications to a specific telephone number or numbers, you need to request that only a designated number or numbers be used for these purposes. If you inform us that you do not want to receive such communications, we will stop sending these communications to you.

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, subject to additional federal and state privacy protections that may limit or prohibit disclosure of certain records, including federally protected substance use disorder records.

Some health information is subject to stricter federal or state privacy laws. This may include information related to alcohol and substance use, genetics, mental health, HIV/AIDS, or minors' information. When those laws apply, we follow the more restrictive requirements.

Special Protections for Substance Use Disorder Records:

Certain records related to substance use disorder (SUD) services are protected by federal law (42 CFR Part 2). Although we are not a SUD program, we may receive information from a SUD program regarding your treatment. These records generally may not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you without your written consent or a court order accompanied by a subpoena or other legal requirement compelling disclosure issued after we and you were given notice and an opportunity to be heard.

When permitted by federal law, these records may be redisclosed for treatment, payment, or health care operations in accordance with applicable privacy requirements.

Substance use disorder counseling notes have enhanced confidentiality protections like psychotherapy notes under HIPAA and require specific patient written authorization for disclosure unless the law permits otherwise. In all other situations, we will follow our privacy practices regarding the disclosure of substance use disorder information as stated in this Notice.

In addition, if we use this information to raise funds for our benefit, we must first provide you with a clear and conspicuous opportunity to elect not to receive any fundraising communication.

Disclosures We Are Prohibited from Making

Federal law prohibits certain disclosures of health information. For example, federally protected substance use disorder records may not be disclosed for employment decisions or legal proceedings without proper authorization or a qualifying court order.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information. Once we disclose your health information based on your authorization or as legally permitted under state and federal law as described in this Notice, the disclosed health information may no longer be protected and may be re-disclosed by the recipient without your knowledge or authorization.
- 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.

These protections apply to health information we create and receive from other providers. For more information visit: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Breach Notification

A breach occurs when your protected health information is acquired, accessed, used, or disclosed in a manner not permitted by HIPAA which compromises the privacy or security of your information. Not all types of breaches require notice, but if notice is required, we will provide such notification without unreasonable delay, but in no case, later than 60 days after we discover the breach.

CHANGES TO THE TERMS OF THIS NOTICE

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

PRIVACY OFFICER CONTACT INFORMATION

Phone: 316-262-2415

E-mail: privacy@hunterhealth.org

DISCRIMINATION IS AGAINST THE LAW:

Hunter Health Clinic complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Hunter Health Clinic:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Compliance Officer. If you believe that Hunter Health Clinic has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with:

Compliance Officer
Hunter Health Clinic
527 N. Grove
Wichita, KS 67214
316-262-2415
Fax: 316-264-4734

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Privacy Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

NOTICE OF NONDISCRIMINATION TAGLINES

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-316-262-2415.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-316-262-2415.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-316-262-2415。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-316-262-2415.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-316-262-2415. 번으로 전화해 주십시오.

ໂປດຊາວປາ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-316-262-2415..

ملحوظة: 1-316-262-2415 إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم -

(رقم هاتف الصم والبكم: 1-316-262-2415)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-316-262-2415.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-316-262-2415。まで、お電話にてご連絡ください。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-316-262-2415.

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (1-316-262-2415 تماس بگیرید.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-316-262-2415.

သတိပြုရန် - အကယုၣ် သဠုၣ် ဂျမ္ဗူၣ်ကား ကို ဝေလုၣ်ပါက၊ ဘာသာစကား အကူအညီ အခမဲ့၊ သဒ္ဒါအကြံကု စီစဉ်ဆောင်ရွက်ပေးပါမည့်။

ဖုန်းနံပါတ် 1-316-262-2415. သုၣ်၊ ဝေလုၣ်ပါ။

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-316-262-2415.

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-316-262-2415.

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: _____

Lot/Apt #: _____

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

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

Ethnicity: Not Hispanic or Latino Mexican, Mexican American, Chicano/a Puerto Rican Cuban

Other Hispanic Latino or Spanish-Origin 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: _____

IN CASE OF EMERGENCY

Who should we contact?

First Name: _____ Last Name: _____ Relationship: _____

Street Address: _____ City _____ State _____ Zip Code _____ Primary Phone _____

Patient Registration Form I



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		<input type="checkbox"/> 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



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



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



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



BASIC INFORMATION

NAME		TODAY'S DATE
DATE OF BIRTH	MARITAL STATUS MARRIED SINGLE DIVORCED WIDOW / WIDOWER	
WORK STATUS / OCCUPATION	PREFERRED PHARMACY	
SEX AT BIRTH MALE FEMALE	GENDER IDENTIFICATION (ex. male, female, transgender, gender neutral, non-binary...)	
SPECIALISTS / OTHER CARE PROVIDERS		

SURGERY (including any eye/ear surgeries and hysterectomy or breast procedures)

LIST ALL SURGERIES, INCLUDE YEAR (Note left-side or right-side, when applicable)

PAST AND PRESENT MEDICAL PROBLEMS (circle and describe)

CARDIOVASCULAR	EYES, EARS, NOSE, THROAT	ENDOCRINE
HIGH BLOOD PRESSURE	CATARACT	THYROID DISEASE LOW HIGH
HIGH CHOLESTEROL	GLAUCOMA	DIABETES
PERIPHERAL ARTERY DISEASE	HEARING PROBLEM	OSTEOPOROSIS
HISTORY OF BLOOD CLOT	SINUSITIS, ALLERGIES	NO PROBLEMS
HISTORY OF HEART RHYTHM DISORDER (describe)	DENTURES, IMPLANTS	NEUROPSYCHIATRIC
HEART DISEASE (describe)	VISION PROBLEM (describe)	ANXIETY
NO PROBLEMS	NO PROBLEMS	DEPRESSION
GASTROINTESTINAL	INFECTIOUS DISEASE	BIPOLAR
GERD	HISTORY OF CHICKEN POX / SHINGLES	SEIZURES
DIVERTICULOSIS	HISTORY OF TUBERCULOSIS	MEMORY PROBLEMS / DEMENTIA
COLON POLYPS	HIV	MIGRAINE
HEMORRHOIDS	HEPATITIS A B C	NEUROPATHY
LIVER DISEASE (describe)	HISTORY OF MRSA	SCHIZOPHRENIA
BOWEL DISEASE (describe)	NO PROBLEMS	HISTORY OF STROKE
NO PROBLEMS	PULMONARY	OTHER MOOD DISORDER (describe)
GENITOURINARY	ASTHMA	NO PROBLEMS
RECURRENT UTI	COPD / EMPHYSEMA	CANCER
URINARY INCONTINENCE	SLEEP APNEA	TYPE / LOCATION
PROSTATE ENLARGEMENT	NO PROBLEMS	YEAR
KIDNEY STONES	RHEUMATOLOGY	TREATMENT SURGERY CHEMO RADIATION
KIDNEY DISEASE (describe)	ARTHRITIS	ONCOLOGIST
GYNECOLOGIC DISEASE (describe)	GOUT	NO CANCER
NO PROBLEMS	RHEUMATOID ARTHRITIS	OTHER PROBLEMS
	FIBROMYALGIA	PLEASE LIST
	NO PROBLEMS	

REVIEW OF SYMPTOMS (circle all symptoms that you have had in the last few days)

GENERAL	ENDOCRINE	HEMATOLOGY
CHILLS FATIGUE FEVER NIGHT SWEATS WEIGHT GAIN / LOSS	COLD INTOLERANCE EXCESSIVE THIRST HAIR LOSS HEAT INTOLERANCE	BLEEDING PROBLEMS EASY BRUISING
NEUROLOGICAL DIFFICULTY SPEAKING FAINTING HA LOSS OF STRENGTH MEMORY LOSS SEIZURES TINGLING / NUMBNESS TREMOR	RESPIRATORY COUGH SHORTNESS OF BREATH WHEEZING	SKIN DISCOLORATION ITCHING CHANGE IN MOLES OR SPOTS RASH
PSYCHOLOGICAL ANXIETY DEPRESSED MOOD DIFFICULTY SLEEPING MENTAL OR PHYSICAL ABUSE	CARDIOVASCULAR CHEST PAIN PAIN IN LEGS WITH WALKING FLUID ACCUMULATION IN LEGS DIFFICULTY BREATHING WHEN LAYING FLAT PALPITATIONS	URINARY BLOOD IN URINE DIFFICULTY URINATING KIDNEY PROBLEMS PAINFUL URINATION
EYE BLURRY VISION EYE PAIN	GASTROINTESTINAL ABDOMINAL PAIN BLOOD IN STOOL CONSTIPATION DIARRHEA HEARTBURN NAUSEA VOMITING	BREAST LUMP PAIN NIPPLE DISCHARGE SKIN CHANGES
ENT RUNNY NOSE CONGESTION DIFFICULTY SWALLOWING EAR PAIN RINGING IN EARS SNORING SORE THROAT	MUSCULOSKELETAL MUSCLE ACHES JOINT PAIN JOINT SWELLING	WOMEN PELVIC PAIN MENOPAUSAL SYMPTOMS GENITAL SORES / RASH IRREGULAR PERIODS VAGINAL DISCHARGE / ITCHING
	ALLERGY / IMMUNOLOGY IMMUNE DEFICIENCY SEASONAL ALLERGIES	MEN ERECTILE DYSFUNCTION PENILE DISCHARGE GENITAL SORES / RASH
		OTHER

FAMILY HISTORY (List major health problems of blood relatives, if known. If deceased, list age at death.)

MOTHER	FATHER
SIBLINGS	CHILDREN
GRANDPARENTS	AUNT / UNCLE

 CHECK IF YOUR FAMILY HISTORY IS UNKNOWN DUE TO ADOPTION OR OTHER CIRCUMSTANCES.

SOCIAL HISTORY (circle and provide details)

SMOKING (# packs per day) eCIGARETTE / HOOKAH / VAPOR SNUFF / CHEW (# cans per day) ALCOHOL (# per week)	WHO DO YOU LIVE WITH? DO YOU FOLLOW A SPECIAL DIET? YES / NO DO YOU EXERCISE? DO YOU SLEEP WELL?
STREET DRUGS: MARIJUANA / CBD / KRATOM (please list others)	DO YOU HAVE ANY: ADVANCED DIRECTIVES / LIVING WILL / DURABLE POWER OF ATTORNEY



SEXUAL / REPRODUCTIVE HISTORY (Please answer questions based on sex at birth.)

NUMBER OF BIOLOGICAL CHILDREN: DO YOU USE ANY FORM OF CONTRACEPTION? YES / NO
NUMBER OF ADOPTED CHILDREN: IF YES, WHAT FORM?
ARE YOU CURRENTLY SEXUALLY ACTIVE? YES / NO HAVE YOU EVER HAD A SEXUALLY TRANSMITTED DISEASE? YES / NO
ARE YOUR PARTNERS: MEN / WOMEN / BOTH IF YES, WHICH: HERPES / GONORRHEA / CHLAMYDIA / HIV
HOW MANY SEXUAL PARTNERS HAVE YOU HAD IN THE GENITAL WARTS / SYPHILIS / TRICHOMONAS
LAST YEAR?

WOMEN

DO YOU HAVE PERIODS? YES / NO NUMBER OF CESAREAN SECTIONS:
FIRST DAY OF LAST PERIOD: REASON?
LENGTH OF PERIODS: NUMBER OF MISCARRIAGES:
HOW OFTEN DO YOU HAVE A PERIOD? NUMBER OF STILLBIRTHS:
HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR? YES / NO NUMBER OF ABORTIONS:
IF YES, WHEN AND OUTCOME? NUMBER OF TUBAL / ECTOPIC PREGNANCIES:
HOW MANY TIMES HAVE YOU BEEN PREGNANT? ANY PROBLEMS WITH PREGNANCIES OR DELIVERIES?
NUMBER OF VAGINAL DELIVERIES: ANY PROBLEMS WITH POSTPARTUM DEPRESSION?

MEN

HAVE YOU EVER BEEN DIAGNOSED WITH A PROSTATE ISSUE OR HAD A PROSTATE BIOPSY?
DO YOU CURRENTLY STRUGGLE WITH STARTING, STOPPING, OR MAINTAINING A URINARY STREAM?
DO YOU HAVE A HISTORY OF TESTICULAR OR TESTOSTERONE PROBLEMS?

PRIMARY PREVENTATIVE CARE SCHEDULE

Table with columns: VACCINATIONS, DATE, WOMEN, DATE, MEN, DATE. Rows include Tetanus, Influenza, Pneumonia 13, etc., and dental/eye exam questions.

MEDICATIONS

Table with columns: CURRENT MEDICATIONS (include dose and frequency) WRITE ON BACK IF NECESSARY., MEDICATION ALLERGIES. Includes instruction: PLEASE INCLUDE any Durable Medical Equipment such as Oxygen, CPAP, BIPAP, etc.



HUNTER HEALTH

PATIENT AUTHORIZATION FOR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION

GENERAL INFORMATION

LAST NAME: FIRST NAME:

MAIDEN NAME OR OTHER NAME USED: DATE OF BIRTH: PHONE:

ADDRESS:

CITY: STATE: ZIP:

I HEREBY AUTHORIZE: (PLEASE PRINT) TO RELEASE TO: (PLEASE PRINT) FACILITY: ADDRESS: PHONE: FAX:

THE FOLLOWING INFORMATION FROM MY RECORDS: COPY OF COMPLETE HEALTH HISTORY LABORATORY REPORTS X-RAY REPORTS BEHAVIORAL HEALTH OTHER: (PLEASE SPECIFY)

COVERING THE PERIOD FROM:

INFORMATION IS TO BE DISCLOSED FOR THE PURPOSE OF:

THIS AUTHORIZATION WILL EXPIRE ON: (SPECIFY DATE, EVENT, OR CONDITION)

I understand that I have the right to revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing and present my written revocation to Hunter Health. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in sixty (60) days from the date below.

I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records, \$16.00 for pages 1-10, \$28.00 for pages 11-50 (\$16.00 for pages 1-10 and \$12.00 for pages 11-50), an additional \$0.35 per page for anything above 50 pages. A records retrieval fee of \$20.00 plus \$0.35 per page will be charged for records stored off site.

Hunter Health is not responsible for completeness, legibility or ommittance caused by the copying of any medical records from another institution.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN RELATIONSHIP TO PATIENT DATE

PATIENT'S NAME PRINT NAME OF PATIENT OR LEGAL GUARDIAN

FOR HUNTER HEALTH STAFF USE ONLY: COMPLETED BY: DATE: REVOKED DATE: HANDED TO PATIENT FAXED MAILED OTHER: