Proactive Patient Care (PPC) – Patient Agreement

Welcome to Guadalupe Clinic

Guadalupe Clinic provides health care services and medication assistance to persons who are 18 years of age or older, do not have health insurance/coverage and whose household income is equal to or less than 200% of the Federal Poverty Level. Communication is at the center of the care services that we provide, and this agreement explains how we will work together to ensure that your health care needs are met.

Services include primary care, well and sick care, women's health services and available specialty services as prescribed by your primary care provider. Other services provided as prescribed include lab testing, x-ray services and medication assistance.

Guadalupe clinic will make every effort to address your health care needs in a timely manner, same day if possible. We cannot guarantee that You will not need to seek treatment in an urgent care or emergency department setting under certain circumstances.

It is not the policy of Guadalupe clinic to prescribe chronic controlled substances on Your behalf, including opioid medications, benzodiazepines, and other stimulants.

Students in health care training may participate in the delivery of medical care or be observers in the care provided under the supervision of instructor and medical staff.

Agreement:

- Provide the required documentation that validates income eligibility annually or as needed.
- Attend all scheduled appointments. If unable to attend scheduled appointment call the clinic at (316) 264-6464 (St. Francis Clinic) or (316) 207-1986 (S. Hillside Clinic) in advance to cancel/reschedule.
- Demonstrate compliance with prescribed treatments and medications.
- Communicate healthcare concerns and updates by calling (316) 372-5206 (St. Francis Clinic) or (316) 201-1986 (S. Hillside Clinic)
- Notify the clinic at least 48 hours in advance for medication refills. If the prescription was filled by a local pharmacy, contact the pharmacy for the refill request.
- **No-show Consequences:** Two No-Shows within 12 months will result in you not being allowed to schedule an appointment for 6 months unless you pay a $20 fee to restart your No-show rolling calendar.

Protected Health Information (PHI):

Guadalupe clinic may submit PHI including medical record information and registration documents for purpose of ongoing health management as needed. Your PHI will not be disclosed for reasons unrelated to the delivery of Services, or the provision of other health care services on Your behalf. Guadalupe clinic will adhere to its obligations regarding your privacy rights as identified in the provided **Notice of Privacy Practices** document.

Communications may include e-mail, facsimile, video chat, texting, and cell phone, and such communications by their nature cannot be guaranteed to be secure or confidential. If You initiate a conversation in which You disclose PHI on any of these communication platforms, then You authorize Guadalupe clinic to communicate with You regarding all PHI in the same format.

Consent and Acknowledgement: I give consent to Guadalupe Clinic to discuss my health information with the following individual: _____

My signature of this document states understanding and consent of implementation of this Patient Agreement.

Patient Name (print) _____ DOB: _____

Patient Signature: _____ Date: _____

Patient Information and Eligibility Form

Form A – Revised 2022—04-11

Eligibility

1. **Do you have health insurance/coverage?** Yes No Examples of health insurance/coverage include Medicare, Medicaid/KanCare, TRICARE, Affordable Care Act (ObamaCare) Marketplace plans, workers' compensation, COBRA, Blue Cross Blue Shield, Aetna, UnitedHealthcare, Humana, Cigna, etc.
2. **Annual household income**: $_____ **# of persons in household**: Household income must be equal to or less than **200%** of the Federal Poverty Level. Household refers to patient, spouse/partner, and dependent children.

Required Documentation

□ **Photo I.D.** □ **Proof of Income** Patients must provide one of the following documents: • Last year's federal tax return (IRS Form 1040); • Wage and Income Transcript (IRS Form 4506-T); • Low Income Energy Assistance Program (LIEAP) benefit amount/approval letter; or • Food Assistance Program ("food stamps") benefit amount/approval letter.	**ATTENTION:** Patients must submit required documentation for staff to verify eligibility for clinic services and medication assistance. **Required documentation must be submitted by next office visit or medication refill request**. Failure to do so may result in loss of services/assistance.

Patient Information

Name: _____ **Date of Birth:** _____

Social Security #: _____ **Citizenship:** U.S. Citizen U.S. Permanent Resident Other

Home Address: _____ □No Home Address

City: _____ **State:** _____ **Zip:** _____ **County:** _____

Phone: _____

Circle answers below:

Sex: Male Female **Race/Ethnicity:** White Black Hispanic/Latino Asian Other

Language: English Spanish English/Spanish Other

Mode of Transportation: Personal vehicle Ride with family/friend Bus/Taxi Walk/Bike Other

Employment Status: Employed Unemployed Disabled Retired Student **Veteran:** Yes No

Emergency Contact

Name: _____ **Phone:** _____

Certification

I certify the above information on this form is accurate to the best of my knowledge. I understand the above information and Proof of Income documentation I provide will be used by staff to determine (verify) eligibility for services at Guadalupe Clinic.

Patient Signature: _____ **Date:** _____

STAFF USE ONLY:

Chart ID#: _____ □New □Recert _____ **Form Received (Initial):** **Eligibility Verified (Initial/Date):** _____

Medication List

Patient Name: _____ **DOB:** _____

Allergies: _____

_____

MEDICATION	DOSE	HOW OFTEN	REASON FOR TAKING

Other (Oxygen - # of liters; CPAP): _____

Date: _____ **Patient Signature**: _____

ATLAS MD

Patient History Form	
Name:	Birth date:
Marital Status:	Occupation:

Allergies to Medications, Latex or Dyes	☐None ☐ Yes (please list)

Medications (Prescriptions, non-prescriptions, vitamins and supplements) ☐None ☐ Yes (please list)	

Surgeries/Hospitalizations/Serious Injuries	Year

Immunizations	N	Y			N	Y
Hepatitis B Series				Recent Pneumonia Vaccine		
Gardasil Series				Recent Flu Vaccine		
Chicken Pox immunization or disease				Positive TB Screening		

Health Maintenance	No	Yes	(Year)			No	Yes	(Year)
Colonoscopy					Bone Density			
Mammogram					Eye Exam			
Pap Smear					Physical Exam			

Social History	No	Yes	
Smoking			Pack(s)/day /years ☐ Quit
Alcohol			Drinks/day drinks/week
Caffeine			Drinks/day
Recreational Drugs			
Special Diet			If yes describe:
Regular Exercise			If yes describe:
Sexually Active			☐ Men ☐ Women ☐ Both

GYN History	OB History
Age of first mensus: ( ) Menopause ☐ N ☐ Y (if yes Age:)	Total Number of Pregnancies: ( )
Regular Periods ☐ N ☐ Y Painful Periods ☐ ☐Y	Full Term ( ) Pre Term ( )
PMS ☐ N ☐ Y – if yes describe N	Miscarriages ( ) Abortions ( )
Abnormal Pap: – if Yes approximate date ( )	Tubal ( )
Pain with intercourse: ☐ N ☐ Y	Content with sex life: ☐ ☐Y N

Medical History (please check if positive)

ENT		GENITOURINARY		SKIN	
	Eye Problems		Urinary Infections		Psoriasis
	Sinus Problems		Kidney Disease/Stones		Skin Disorders
	Hearing Loss		Erectile Dysfunction		Melanoma
			STD		
CARDIOVASCULAR			Urinary Incontinence		
	Abnormal EKG	MUSCULOSKELETAL		PSYCH	
	Chest Pain		Arthritis/Osteo		ADD/ADHD
	Heart Attack		Arthritis/Rheumatoid		Anxiety
	Heart Disease		Gout		Depression
	High Blood Pressure		Neck/Spinal Problems		Memory Loss
	High Cholesterol	NEUROLOGICAL			OCD
	Stroke		Concussion		Suicidal Thoughts/attempt
	Peripheral Vascular Disease		Headaches		
PULMONARY			Migraines		
	Asthma		Epilepsy/Seizures		
	Emphysema/COPD	HEMATOLOGICAL			
	Shortness of Breath		Anemia		
	Sleep Apnea		Bleeding Disorders		
GASTROINTESTINAL			Blood Clots		
	Acid Reflux		Cancer		
	Constipation		Sickle Cell Disease		
	Diarrhea	ENDOCRINE			
	Irritable Bowel		Diabetes		
	Gall Bladder Disease		Thyroid Disease		
	Hernia		Pancreatitis		
	Liver Disease				

Family History (please check all applicable boxes)

Illness	Father	Mother	Sibling	Child	Maternal G-mother	Maternal G-father	Paternal G-mother	Paternal G-father	Other
Asthma									
Bleeding Disorders									
Breast Cancer									
Colon Cancer									
Depression/Anxiety									
Diabetes									
Drug/Alcohol Addiction									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Kidney Disease									
Leukemia									
Liver Disease									
Lung Cancer									
Osteoporosis									
Ovarian Cancer									
Pancreatic Cancer									
Rheumatoid Arthritis									
Stroke									
Thyroid Disease									
Other:									

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Notice of Privacy Practices

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.**

Get a copy of your medical record
- You can ask to see or get a copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've 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, health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- We participate in the electronic exchange of health information with other health care providers in Kansas through an approved health information organization. Unless you direct otherwise, your electronic health records will be accessible through the exchange to properly authorized users for purposes of treatment and health care operations only.
- If you have questions about the electronic health information exchange or want to restrict access to your records through the exchange, contact Kansas Health Information Technology at 785-296-8627 or visit **www.kanhit.org** for more information.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time. 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.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 3.
- You can 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 **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- 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.*

Our Uses and Disclosures:
How do we typically use or share your health information? We typically use or share your health information in the following ways:

- **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, or you are referred to a specialist for additional care.*
- **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 health information about you to manage your treatment and services. At times we may need to share your information with the City of Wichita, Sedgwick County or DCF for purposes of reporting and payments under Project Access.*

How else can we use or share your health information?
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

- **Do 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're 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 will let you know promptly if a breach occurs that may have compromised the privacy or security of your 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.

Patient Eligibility for Available Services

To be eligible for Guadalupe Clinic services, patients must be 18 years of age or older, not have health insurance/coverage and have a household income equal to or less than 200% of the Federal Poverty Level:

Persons in Family/Household (Includes patient, spouse/partner, and dependent children	**Household Income at 200% of Federal Poverty Level**		
	Annual	Monthly	Weekly
1	$30,120	$2,510	$579
2	$40,880	$3,406	$786
3	$51,640	$4,303	$993
4	$62,400	$5,200	$1,200
5	$73,160	$6,096	1,406
6	$83,920	$6,993	$1,613
7	$94,680	$7,890	$1,820
8	105,440	$8,786	$2,027

** Table based on 2022 guidelines: https://aspe.hhs.gov/poverty-guidelines*

Proof of Income

Patients must provide one of the following documents:

- o Last year's federal tax return (IRS Form 1040); and last 2 paycheck stubs.
- o Wage and Income Transcript (IRS Form 4506-T); At 555 N Woodlawn Blvd, Wichita, KS 67208
- o Low Income Energy Assistance Program** benefit amount/approval letter; or
- o Food Assistance Program** ("food stamps") benefit amount/approval letter.

Services Available to Guadalupe Clinic Patients

PRIMARY CARE SERVICES

- Physician Visits
- Women's Wellness
- Diabetic Management
- Pregnancy Tests

PUBLIC HEALTH SERVICES

- TB Tests
- COVID-19 Tests and Vaccines
- Seasonal Vaccines

SPECIALTY SERVICES*

- Behavioral Counseling
- Cardiology
- Dermatology
- Endocrinology
- ENT
- Gastroenterology
- Orthopedics
- Physical Therapy/Physiatry
- Podiatry
- Pulmonology
- Urology
- Vision Care

** Please note that you must see a primary care provider before scheduling with one of our specialists.*