



Cheyenne Health and Wellness Center
2508 East Fox Farm Road #1A, Cheyenne, WY 82007
Phone (307) 635-3618 Clinic Fax (307) 635-1442
<http://www.cheyennehealth.org>

Thank you for choosing the Cheyenne Health and Wellness Center for your healthcare needs. We look forward to having you as a patient and helping in any way that we can.

Each time you come to our office it costs over \$100 to provide you with the care you receive. Cheyenne Health and Wellness Center receives federal grant dollars to help offset the cost of care for uninsured patients. Patients who are not covered under Medicare, Equality Care, Kid Care CHIP, or private insurance (other than a high deductible plan) may apply for CHWC's sliding fee discount. CHWC's fee schedule is based on household income and family size. For patients who qualify for the discount, CHWC has a minimum **\$20 per visit charge** which covers all charges incurred as part of a single visit. This payment does not cover prescription drugs, or dental services. Payment is requested when you check in at the front desk for your appointment. When applying for the sliding fee discount, **all household members** must provide income documentation such as: pay stubs for the last 30 days, employer statement of income, income tax return for the prior year, social security income statement, alimony or child support statement or unemployment services statement. CHWC is REQUIRED to maintain current documentation for the sliding fee discount which shows that your current household income does not exceed 200% of the federal poverty level.

Since you may not have known about this requirement, we are able to waive this requirement for your first visit. However, it is important that you bring proof of your household income for your next visit, or you will be required to pay the full fee for your visit instead of just \$20.

For patients with insurance, Cheyenne Health and Wellness Center will be happy to bill your health insurance for you as a courtesy. In order for us to do so, you must provide a copy of your insurance card. If this information is not provided, your insurance will not be billed. Remember, this is only a courtesy. Payment of insurance co-pays or co-insurance amounts will be expected when you check in for your appointment. Patients who have a high deductible health insurance plan may apply for the sliding fee discount.

Remember that you, the patient, are ultimately responsible for payment of the services rendered.

Appointment Policy

We are always trying to develop strategies to meet the health care needs of the people we serve. Seeing your established provider is important because they understand your health history. We ask your cooperation with us so that each patient can get the attention they need in the timeliest manner possible. This is accomplished by making a scheduled appointment with your established provider. If you are more than 10 minutes late after your scheduled appointment, you will be considered a walk-in and will be offered the same options as a walk-in patient. Please note that if an established patient does not show for a scheduled appointment three times, that patient will only be seen on a walk-in basis. To regain the privilege of making an appointment, the patient must petition to Senior Management for reinstatement of appointment privileges.

We know that some health care problems come up all of a sudden. We keep some appointment slots open each day to be filled by these urgent needs. CHWC providers see patients that have urgent health care needs on a first come – first served basis. This may result in an extended wait, but eventually those patients are seen that day. True emergencies may be seen ahead of others whose needs are not so critical. Your patience and understanding is greatly appreciated.

If you have any question about our policies, please do not hesitate to ask for further explanation at the front desk and we will be happy to assist you.



PATIENT INFORMATION				DATE:	
Last Name		First Name (Legal)		Middle Name	
Birth Date		Age		Sex M F	
Mailing Address			City		State
					Zip Code
Home Phone Number			Social Security Number		Marital Status: Single Married Divorced Widowed
Employment: Full time Part time Unemployed Student					
Employer Name			Employer Phone Number		Employer Address
I have no insurance, or a high deductible plan, and I would like more information about the sliding fee (income based) discount Yes No					
PLEASE PROVIDE PROOF OF INCOME (SUCH AS PAY STUBS OR INCOME TAX RETURN) FOR SLIDING FEE DISCOUNT					
Which Ethnic Group do you feel you belong to? Native American African American Hispanic Caucasian Other					Primary Language
Are you an Agricultural Worker Yes No		Are you a Homeless Yes NO		If so where do you live? Street Shelter Relative Other	
INSURANCE INFORMATION AUTHORIZATION AND ASSIGNMENT					
Who is Responsible for this Account?				Relationship to Patient	
Primary Insurance Company Name and Address				Primary card holder	
Primary card holder Social Security #		Card Holder Birth Date		Policy I.D. Number	Policy Group #
				Start Date	
Card Holder Address			Card Holder Phone #		Card Holder Employer Name
SECONDARY INSURANCE					
Secondary Insurance Company Name and Address				Secondary Card Holder	
Secondary Card Holder Social Security #		Secondary Card Holder Birth Date		Policy ID #	Policy Group #
				Start Date	
Card Holder Address			Card Holder Phone #		Card Holder Employer Name

ASSIGNMENT AND RELEASE

I authorize **CHEYENNE HEALTH AND WELLNESS CENTER (CHWC)** to disclose medical information as necessary to receive payment, and assign all benefits, if any, directly to **CHWC** that otherwise might be payable to me for services rendered. I understand that CHWC may also release medical information about me to physicians or other health care providers who may be involved in my continued care. I understand that this authorization will remain in effect for twelve (12) months. If I choose to seek medical care with another provider, I understand that the treatment and information may still be shared with my insurance or other medical carrier. I understand that CHWC will file an initial claim with Medicare, Medicaid, insurance, or any other third party, if I have provided and signed the necessary information and/or forms. I understand that I am completely financially responsible for all of my charges whether or not they are covered by my insurance carrier. I also agree to be responsible for payment of any services rendered if my insurance company takes longer than sixty (60) days from date of service. If this occurs, I will be responsible for seeking reimbursement from my insurance company. I authorize the use of this signature on all insurance submissions. I understand that if I fail to make a good faith effort to keep my account current **CHEYENNE HEALTH AND WELLNESS CENTER** reserves the right to refuse non-acute medical services and to engage a collection agency for any outstanding balances.

Responsible Party Signature: _____

Relationship: _____ Date: _____

EMERGENCY INFORMATION

In Case of Emergency, Who Should We Contact?

Name: _____ Phone #: _____ Relationship to Patient: _____



PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

YOU HAVE THE RIGHT:	YOU HAVE THE RESPONSIBILITY:
<ol style="list-style-type: none"> 1. To care or treatment that is respectful and recognizes a person’s dignity and provides for personal privacy to the extent possible during the course of treatment. 2. To receive quality care with freedom from discrimination. 3. To participate in the development and revision of a plan of service to best meet your individual needs. 4. To receive complete medical information to participate in you health care, including diagnosis, treatment and prognosis. 5. To refuse service, including medical and mental care, to the extent allowed by law. 6. To confidentiality of service including information you provide while receiving services, except that for which law requires. 7. To receive necessary information before agreeing to consent to the release of information to outside agencies. 8. To review the records of services you have received at CHWC when requested by you in writing. 9. To file a complaint for any violation of these rights. 10. To know names and professional status and experience of the staff that is providing your care or treatment. 11. To know if the facility participating in teaching programs, research and/or experimental programs. 12. To be informed of the facility’s rules And regulations as they apply to you. 	<ol style="list-style-type: none"> 1. To keep all appointments or cancel any appointment you do not or cannot keep with CHWC or related agency. 2. To provide accurate information about your present and past medical condition and report any unexpected changes in your condition to your healthcare provider. 3. To follow the treatment plan that you and your health care provider agree upon, to take medication as prescribed and to inform staff when you do not understand the service being provided to you. 4. To provide accurate proof of your financial situation and to meet program requirements. You have the responsibility to pay your portion of charges at the time of service. 5. To recognize the effect that your lifestyle choices may have on your health. 6. To respect the confidentiality of other patients receiving services at CHWC. 7. To inform CHWC or your provider of your intentions not to follow the service plan or of your decision to discontinue service at CHWC. 8. To treat staff and patients of CHWC with dignity and respect and to abide by all clinic rules. 9. To report any complaint to your provider or his/her supervisor, by following clinic grievance procedure, which will be explained upon request.



CHEYENNE HEALTH AND WELLNESS CENTER (CHWC) RIGHTS AND RESPONSIBILITIES

CHWC HAS THE RIGHT TO:	CHWC HAS THE RESPONSIBILITY TO:
<ol style="list-style-type: none"> 1. Change the time of patient appointments for scheduling efficiency and prioritization based on patient needs. 2. Remove any patient, or visitor, at its discretion from any clinic or office area if that patient or visitor abuses, in any way, any CHWC employee or patient. 3. Review a patient’s financial records if that patient is applying for a reduced rate program. 4. An accurate health history of a new patient. 5. Request any medical records from any physician or medical institution regarding a patient’s health history, with the authorization of the patient. 6. Collect payment for any incurred expense by a patient at the clinic location. 7. Change a patient’s health care provider at the request of the current health care provider by authorization of the Medical Director. 8. Revise any policy regarding patient or CHWC rights and responsibilities by approval of the governing Board of Directors. 	<ol style="list-style-type: none"> 1. Have you seen by your health care provider as close to the time of your scheduled appointment as possible noting, however, that other patient needs and health care emergencies may affect the daily schedule. 2. Allow the patient or guardian to examine his/her billing account and offer the explanation of the charges to that patient or third-party payer. 3. Forward all requested patient records to any provider or health care institution upon receiving written authorization from that patient. 4. Through its health care providers, to fully explain to the patient or guardian any diagnosis, prognosis, and test results and any risk associated with any test, treatment, or medication involved in a patient’s health care program. 5. Offer you helpful guidelines pertaining to advanced directives (living will and durable power of attorney), but it is the patient’s responsibility to create the actual document.



CONSENT FOR TREATMENT

Health and Medical Care Consent: I voluntarily consent to and authorize Cheyenne Health and Wellness Center, its employees, agents and affiliates, to provide such medical care (including evaluation, diagnostic procedures, and medical treatment) as may be deemed necessary and appropriate by my physician, his/her assistants, or his/her designees. Cheyenne Health and Wellness Center periodically conducts training programs for health care professionals. These persons may be observing or participating in Cheyenne Health and Wellness Center's treatment programs. They will be under the direct supervision of licensed professionals. I understand that I have the right to refuse to have trainers participate at any time, in my care.

Patient Signature _____ Date _____

If the patient is unable to sign or is a minor, signature of authorized parent, guardian, or representative:

Authorized Signature _____ Date _____

Relationship to patient _____

WYOMING IMMUNIZATION REGISTRY

I understand that the state of Wyoming maintains an immunization registry. The benefits of the registry are to prevent duplication of immunizations, provide parents with timely notification of immunizations due, and to serve as a backup in case you lose your child's record of vaccination. Immunization records are only accessible by authorized health care providers, and schools.

- I authorize Cheyenne Health and Wellness Center to enter information regarding my (or my child's) immunizations into the Wyoming Immunization Registry.
- I choose to no longer have myself (or my child) participate in the Wyoming Immunization registry and request that my (or my child's) immunization records be removed from the Wyoming Immunization Registry.

Signature of Patient or Parent/Guardian

Date

CHEYENNE HEALTH AND WELLNESS CENTER
NOTICE OF PRIVACY PRACTICE

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY GET USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.**

CONFIDENTIALITY OF HEALTH INFORMATION

This Notice of Privacy Practice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operations, and for the purposes required by law. Any information concerning a patient's condition, treatment, personal affairs, or records, whether hard copy, computerized or stored in other media, shall be kept confidential. Such information may be released only through or with the approval of an individual or when compelled to do so pursuant to legal process or when applicable by law

DISCLOSURE OF HEALTH INFORMATION

The Cheyenne Health and Wellness Center (CHWC) is committed to providing only the best possible health care to our patients. It will be necessary to use or disclose your protected health information (PHI) to various entities in order to provide you with the highest quality of care available. Disclosures will be made to providers, staff, and other entities for the purpose of treatment, payment, and health care operations.

OTHER DISCLOSURES

Any uses of PHI, other than the Disclosure of Health information listed will require CHWC to obtain written or oral authorization from an individual or his/her representative. In accordance to regulation 164.508(b)(5), an individual or their legal representative has the right to revoke this authorization at any time; the revocation of the authorization must be done in writing except to the extent that:

- The clinic has taken action thereon; or
- If the authorization was obtained as a condition of obtaining insurance coverage.

PATIENT RIGHTS

Patients of CHWC have the right to request restriction to uses and disclosures of protected health information, which include:

- Uses or disclosures of PHI about the individual to carry out treatment, payment, and health care operations.
- Uses or disclosures of PHI to family members, other relatives, or close friends of the individual, or any other individuals identified by an individual.
- CHWC is not required to agree to the request to restrict protected health information per regulation 164.522(ii). We will however make every reasonable effort to accommodate our patients wishes based upon our professional experience.
- An individual may request restrictions on the use and disclosure of his/her PHI by:
 - A) Notify the staff at CHWC in writing of your wish to limit disclosure of your PHI.

An individual has the right to request and receive communications concerning PHI from the provider by reasonable alternative means (fax, mail, electronic) or alternate locations (hospitals, physician's office, legal office). An individual must submit the request for confidential disclosure in writing and specify the means of alternative contact or location. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with the respect to protected health information. If you believe your rights have been violated then you may file a complaint with the U.S. Dept. of Health and Human Services (200 Independence Ave., SW Room 509F, HHH Building, Washington, DC 20201). If you have any objections to this form, please ask to speak with our privacy officer at our main phone number (307) 635-2365.

Your signature below is only acknowledgement that you have received this NOTICE OF PRIVACY PRACTICES.

Print Name

Date

Signature

Birth date.

This notice was published and becomes effective on July 8, 2005.