REGISTRATION FORM
(Please Print and use **BLACK INK ONLY**)

CARROLL: (502) 732-1082 GALLATIN: (859) 567-1591
OWEN: Medical (502) 484-2117
Behavioral Health (502) 484-2595 Dental Clinic (502) 484-5888

TRIAD Health Systems

PATIENT INFORMATION

Last Name	First	Middle Initial	Social Security Number	Birth Date / /

Mailing Address

City/State

Zip

Sex assigned at birth (check one)
- ○ Male
- ○ Female

Physical Address (if different from mailing address above)

City/State/Zip

Home Phone ( ) -

Cell Phone ( ) -
- ○ Check if the same as home phone

Email Address

Preferred Contact Method: (check one)
- ○ Cell phone ○ Home phone
- ○ No contact ○ Regular mail

Gender Identity: (check one)
- ○ Male
- ○ Female
- ○ Transgender Male/Female-to-Male
- ○ Transgender Female/Male-to Female
- ○ Genderqueer, neither exclusively Male or Female
- ○ Decline to Answer
- ○ Other_____

Sexual Orientation: (check one)
- ○ Straight or heterosexual
- ○ Lesbian, Gay, or homosexual
- ○ Bisexual
- ○ Something else
- ○ Do not know
- ○ Decline to Answer
- ○ Other_____

Race: (check all that apply)
- ○ White
- ○ Black
- ○ Pacific Islander
- ○ Asian
- ○ Native Hawaiian
- ○ American Indian/Alaska Native
- ○ Other_____

Ethnicity: (check one)
- ○ Hispanic
- ○ Non-Hispanic

Preferred Language: (check one)
- ○ English ○ Spanish
- ○ Sign Language (ASL)
- ○ Other_____

Marital Status: (check one)
- ○ Single ○ Married
- ○ Divorced ○ Widow
- ○ Separated

Are you Homeless: (check one)
- ○ Yes ○ No

Are you a Veteran: (check one)
- ○ Yes ○ No

Understands English: (check one)
- ○ English is primary language
- ○ Other primary language with interpreter used
- ○ Other primary language used

○ **Interpreter needed for visit** (inform receptionist)

Migrant Worker/Dependent: (check one)
- ○ Dependent of Migrant/ Seasonal Worker
- ○ Migrant/Seasonal Worker
- ○ None

Pharmacy Name:

Pharmacy Location/Phone number:

Responsible Party/Guardian Name:

Responsible Party/Guardian Phone:

INSURANCE INFORMATION (Please give your insurance card and proof of ID to the receptionist)

Insurance Company Name: **Policy No:** **Group No:** **Copay:**

Subscriber Name: **Subscriber SSN:** **Relationship:** **Subscriber DOB:**

RESPONSIBLE PARTY INFORMATION

Person responsible for bill: **Birth Date:** **Address, if different from above:**

IN CASE OF EMERGENCY

Name of local friend or relative to contact in case of emergency: **Relationship to patient:** **Phone No:**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician and for Triad Health Systems, Inc. and/or my Insurance Company to release any information required to process my claim(s). understand that I am financially responsible for any balance.

Patient/Legal Representative/Guardian Signature: **Date:**

OFFICE USE ONLY:
Data entered by (signature): _____
(Check all Systems that apply)
Entered into System: __IMS __Credible __Dentrix

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Health Clinic Medical Information

Please complete the questions below ON THE PATIENT to the best of your knowledge:

1. **Medical History** (Please list any major illnesses, injuries, surgeries and hospitalizations that the patient has had in the past):

   _____

   _____

   _____

   _____

2. Please **list any medication the patient is taking** on a regular basis:

   Medication _____ Strength _____ How Often_____

   Medication _____ Strength _____ How Often_____

   Medication _____ Strength _____ How Often_____

   Medication _____ Strength _____ How Often_____

   Medication _____ Strength _____ How Often_____

   Medication _____ Strength _____ How Often_____

3. Does the patient have **any allergies** to foods/medications/environmental pollens? ___YES _____NO

   If yes, please list **ALL** allergies: _____

4. Does the patient have history of or current use of any of the following **substances** (circle what applies)?

   Tobacco? Yes No Alcohol? Yes No Drugs? Yes No

5. Does anyone in the household have a history of or current use of any of the following **substances** (circle what applies)?

   Tobacco? Yes No Alcohol? Yes No Drugs? Yes No

6. Patient's Family **Physician:** _____
   Doctor's Name Address Phone Number

8. Patient's **Dentist:** _____
   Dentist's Name Address Phone Number

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Please sign and date below to acknowledge that the above information you provided is accurate to the best of your knowledge.

Patient or Parent/Guardian Signature: _____

Date: _____

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FINANCIAL/CONSENT for TREATEMENT

Financial Policy/Authorization for Medical Care and Billing:

Non-covered medical services are the responsibility of the patient, or in the case of a minor, the responsibility of the minor's parents or legally appointed guardian. I understand I am financially responsible for medical services regardless of any divorce decree or court order. This includes services rendered to minors who may be covered by another parent's insurance under a custody agreement. I understand that my insurance policy is a contract between myself and the insurance company, claims submission by Triad Health Systems, Inc. (THS) is performed as a courtesy and THS will not become involved in disputes with my insurance carrier.

I authorize the release of any medical information necessary, to process my claims. I do hereby consent to such medical, dental, and/or surgical examination and treatment (face-to-face or phone/telehealth services) as is necessary and authorize the provider to release to Third Party Sources information necessary to obtain payment for services rendered.

I also consent to authorize the provider to release any referring doctor information necessary for evaluation and treatment.

PATIENT CONSENT FOR TREATMENT:

I *voluntarily authorize the rendering of such care,* including diagnostic tests, procedures and medical treatment (either face-to-face or phone/telehealth) by authorized agents and employees of Triad Health Systems, Inc. (THS), and its medical staff, or designees as may, in their professional judgment, be deemed necessary or beneficial, and may include testing for HIV (the virus that causes AIDS) and other blood borne diseases. I acknowledge that no guarantees have been made as to the effect of such treatments of procedures on my condition. I understand that I have the right to make decisions about my health care or the health care of the person for whom I am legally responsible, including the right to refuse medical and/or surgical procedures: (check one below that applies)

_____I have formulated an Advance Directive (living will, health care surrogate, declaration, durable power of attorney) and request that these directives govern my care according to Kentucky state and/or federal laws. I understand that it is my responsibility to provide THS with a copy of my duly executed Advance Directive and that those directives will not govern my care until they have been filed in my medical record.

_____Advance Directive attached.

_____Advance Directive not attached.

_____I have not formulated an Advance Directive, but I understand that is my right to make decisions regarding my course of treatment, including the execution of an Advance Directive.

Authorization of CONSENT

I have read and understand what I am signing for below and by signing this form, I give my consent for

(patient's name) _____ to receive services (which may include one or all of the following: medical/behavioral health/optometry/dental/phone or audio/telehealth) at Triad Health System's Inc. (THS) Clinics.

THS cannot/will not provide services to the patient without this signed consent (except for an emergency situation).

Right to Terminate or Revoke Authorization: The consent can be withdrawn/revoked at any time by the patient (if 18 yrs. old or older), parent or legal guardian submitting a signed, written revocation to the THS office.

Patient/Parent or Legal Guardian SIGNATURE: _____ **DATE:** _____

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Acknowledgement & Contact Information Form

Patient Name: _____ SSN or Patient ID#: _____ DOB: _____

PATIENT HANDBOOK:
I acknowledge I received a copy of the Triad Health Systems', Inc. Patient Handbook. I understand policies are subject to change at any time. I understand that I may request an updated copy of the handbook at the front desk of any of the Triad Health Systems', Inc. clinics in Carroll, Gallatin or Owen Counties.

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GOOD FAITH ESTIMATE SHEET:
I acknowledge I received a copy of the Triad Health Systems', Inc. Good Faith Estimate Sheet. I understand policies are subject to change at any time. I understand that I may request a copy of the sheet at the front desk of any of the Triad Health Systems', Inc. clinics in Carroll, Gallatin or Owen Counties.

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PATIENT SLIDING FEE SCALE:
I have been offered a copy of the Triad Health Systems', Inc. Sliding Fee Scale Application. If I wish to apply, I understand that it is my responsibility to complete the application and provide any documentation required (such as proof of income, etc.) and any prices quoted at the time of the visit, should be considered an estimate only. I understand that if I do not participate in the Sliding Fee Scale program at this time and/or my information changes that I may reapply at any time by requesting an application from any Triad Health Systems', Inc. clinics in Carroll, Gallatin or Owen Counties.

☐ **I choose to participate in the Sliding Fee Scale at this time** (must complete application attached).

☐ **I choose not to participate in the Sliding Fee Scale at this time.**

****

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of Triad Health Systems', Inc. Notice of Privacy Practices detailing how information may be used and disclosed as permitted under Federal Regulations and Kentucky State Law.

The following questions, (answered only by patient/representative) are asked to fulfill our commitment to protect your privacy:

1. Is there anyone, other than yourself, with whom we may discuss ALL your medical information with? ☐ Yes ☐ No

   If yes, Name: _____ Relationship: _____

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

2. May we leave a message at your home to give test results, reschedule appointments, and/or discuss billing information?
   Yes ☐ No ☐

3. May we contact you at work to give test results, reschedule appointments, and/or discuss billing information?
   Yes ☐ No ☐

4. If unavailable at work, may we leave a voice message or leave a message to return our call with the person who answers the phone? Yes ☐ No ☐

   If we leave a message at work or home, we will identify ourselves as Triad Health Systems, and provide the identity of the Triad staff member calling.

I would like to receive a copy of any amended Notice of Privacy Practices at my address on file? ☐ Yes ☐ No

SIGNATURE REQUIRED:

I have been offered a copy of the Triad Health System's Inc. information acknowledged above:

- Acknowledgement of the Patient Handbook, Good Faith Estimate Sheet, Patient Sliding Fee Scale Application and the Notice of Privacy Practices

I certify that I have read and understand the "Acknowledgement and Contact Information" listed above, and that I am the patient or the patient's legal representative and may execute this consent and accept its terms. I understand that this consent may be revoked at any time except to the extent that action has already been taken.

_____ _____

Client/Representative Signature: **Date:**

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TRIAD Health Systems Inc.

You might qualify for our sliding fee scale discount if:

1. **Your household income is below the amounts listed below**

Number in Household	Total Yearly Income
1	$27,180
2	$36,620
3	$46,060
4	$55,500

Number in Household	Total Yearly Income
5	$64,940
6	$74,380
7	$83,820
8	$93,260

2. **You fill out the "Sliding Fee Scale Application"**
   Applications are available on other side.

3. **You provide proof of income for the household.**
   Household size is defined as the total of all persons living at the address of the person making the application to the SFS program. If the applicant is living in a group home, household size will be one (other residents of the group home will not be included).

Proof of Household Income can include:

1. Current pay stub.
2. Most recent income tax return (Cannot be older than two years)
3. Annual Award Statement from Social Security
4. Social Security Disability, SSI or Pension showing on most recent bank statement
5. Letter from employer stating hourly wage and hours worked per week
6. Qualification Letter from Food Stamp Office
7. Letter from Person providing support to the applicant with amount of support

All forms **MUST** be completed with all required Documentation submitted before eligibility will be effective.

Partial applications cannot be processed.

Updated per 2022 Government Poverty Level

Sliding Fee Scale Application

Date:_____

Patient Name: _____ **DOB:** _____
Please Print

Total Household Members _____

Triad Health Systems, Inc. provides health care services for residents and employees of Gallatin, Carroll and Owen Counties. In order to insure that all residents and employees can continue to receive healthcare that they can access and afford we must bill patients based on their ability to pay.

(Read & initial each line)
I understand that deliberate misrepresentation by/of any household member may result in:

_____ All household members being exclude from the sliding fee scale program

_____ All sliding fee scale discounts received due to misrepresentation will be voided and payable by me.

_____ Prosecution under applicable Federal, State, and Local laws.

List <u>all</u> household members, regardless of age, and income for each. **Attach a copy of each type of income.** Examples of income are *(but not limited to):* Wages, Self-Employment, SSI, Child and/or Spousal Support, RSDI, Workers' Comp, Unemployment, Veterans Pension, Farm Income or Food Stamps

	Name	Date of Birth	Amt. $$	(W) Weekly (BM) Bi-monthly (BW) Bi-weekly (M) Monthly (Y) Yearly	Source of Income
1					
2					
3					
4					
5					
6					
7					
8					

Has this been the average income for the past 12 months? Yes No If no, please explain the differences.

_____

I certify the information given is true and correct. I also certify that I have reported all household income and agree to report any changes in household income. I understand that providing false information on this statement is subject to prosecution under Federal, State and/or Local law's, and can disqualify myself and all of my household members from the Sliding Fee Scale program.

I give Triad Health Systems, Inc. permission to obtain financial information for purposes of verification of household income.

Signature _____ Phone # _____

Address _____ City _____ ST _____ Zip _____

TRIAD Health Systems

CARROLL: (502) 732-1082 GALLATIN: (859) 567-1591 OWEN: (502) 484-2117
OWEN: Behavioral Health (502) 484-2595 Dental Clinic (502) 484-5888

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. We are required by law to protect the privacy of your information, to provide this Notice about our privacy practices, and to follow the privacy practices that are described in this Notice with respect to your medical information. **Please review it carefully.**

YOUR RIGHTS

You have the right to:

Get a copy of your paper or electronic medical record

- Correct your paper or electronic medical record
- Request confidential communication
- Request us to limit the information we share
- Get a list of those with whom we've shared your info
- Get a copy of this privacy notice and Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share info as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care
- Market our services
- Raise funds

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Treat you and bill for your services
- Run our organization
- Help with public health and safety issues
- Do research and Comply with the law
- Contact you for information or reminder calls (phone, mail, etc.)
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- Training staff and students for teaching purposes

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 an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper 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 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/amend your health information about you that you think is incorrect or incomplete, in writing. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days. You must give a reason for the amendment of your request.

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, in writing. We will say yes to all "reasonable" requests. Your request must specify how or where you wish to be contacted.

Request 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, in writing. 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, in writing, 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.

Get a list of those with whom we've shared information for reasons other than treatment, payment or health care operations

- You can ask for an accounting of times we shared your health information, in writing, for 3 years prior to the date you ask, who we shared it with/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'll provide 1 accounting a year free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you received 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 (a copy of the legal document for power of attorney, legal guardianship, etc. must be in your patient record).
- 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, we will not retaliate against you for filing a complaint

- You can file a complaint if you feel we have violated your rights by contacting the HIPAA Privacy Officer at the contact information identified below.
- 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/.

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 if your provider decides it is relevant per their professional judgement.
- Share information, such as location or general condition to FEMA or Red Cross, 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:

- Marketing purposes, sale of your protected health information and sharing of most psychotherapy notes
- When required by law, we will obtain your authorization before releasing certain classes of protected health information, such as substance use, sexually transmitted diseases, drug and alcohol abuse treatment records, mental health records and HIV/AIDS information.
- In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you.

Our Uses and Disclosures

How do we typically use or share your health information? Here are some examples of how we typically use and disclose protected health information without your authorization (a written document that gives us permission to share your health information):

Treatment (we use and disclose your health information to provide treatment and/or joint treatment):

- We can use your health information and share it with other professionals who are treating you, such as for referral purposes to another provider.
  Example: A doctor treating you for an injury asks another doctor in the Northern Ky area you have seen about your overall health condition, labs, etc.

Run our organization (we may use and disclose your health information to carry out health care operations):

- Your information may be used by Triad and disclosed to organizations that assist Triad or comply with its legal obligations as described in this Notice Example: we may disclose information to consultants who assist us in our business activities, these business associates must agree to protect the confidentiality of your information.
- 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 treatment and services, authorized staff may look at portions of your record to perform administration activities and sign-in sheets at registration desk, as well as call you by name in the waiting room when the physician is ready to see you.

Bill for your services (we may use and disclose your health information for payment purposes):

- We can use and share your health information to bill and get payment from health plans or other entities.
- *Example: We share information about you to your health insurance plan so it will pay for your services* that includes information that identifies you, as well as your diagnosis, the procedure performed, the supplies used so that we can be paid for the treatment provided.

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 medication
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research and Respond to organ and tissue donation requests

- We can use or share your information for health research and we can share health information about you with organ procurement organizations.

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.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director if an individual expires.

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
- If you are an inmate at a correctional institution or under the custody of a law enforcement official, we may disclose your PHI

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 reserve the right to change this Notice and the right to make the revised or changed Notice effective for protected health information we already have as well as any information we may receive in the future. We will post a copy of the current Notice in all offices and on the website and you may request a copy.

Other Instructions for Notice

- **Updated/Reviewed: 03/25/2019, 07/05/2022**
- All written request or appeals should be submitted to our HIPAA Privacy Officer at Triad Health Systems, Inc., attention HIPAA Privacy Officer, Gallatin County Clinic and District Office, 441 US Hwy 42 West, Warsaw, KY 41095.
- If you have questions or need further assistance regarding this Notice, please contact the HIPAA Privacy Officer at Triad at (859) 567-1591.
- Who will follow this notice: the privacy practices in this notice will be followed by any health care professional that treats you at any of our locations, by all departments of our organization and by all employed associates, staff and any volunteers of our organization.
- Our practice may contact you or your authorized representative to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The practice might routinely contact patients via telephone at home/cell and/or work, via mail at home, and unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appointments and billing questions if requested on the "Acknowledgement of Receipt of Notice of Privacy Practices" form and signed by patient and/or guardian/responsible party.
- All medical record's requests must be submitted to Triad Systems, Inc. with a valid "Authorization for Release of Confidential Information" form, fully completed and signed by the patient or/or guardian/responsible party. Valid proof of identification must be provided at time of signing the release. If patient is under age of 18, parent must show proof of child's SSN and provide date of birth.

WHEN CALLING TRIAD

Carroll County Clinic
502-732-1082
Carroll Behavioral Health
502-732-1092
Gallatin County Clinic
859-567-1591
Owen County Clinic
502-484-2117
Owen Dental Clinic
502-484-5888
Owen Behavioral Health
502-484-2595

If you get the voicemail, please leave your name, phone number and a brief reason for your call and someone will return your call as soon as possible.

Secure Fax: 859-567-1253
After Hours Call:
859-567-1591: Option "0"
For answering service
For billing questions call:
502-916-3105

Like us on Facebook or our website
www.triadhealthsystems.com

OUR MISSION

Triad Health Systems, Inc. strives to meet the needs of the underserved by promoting wellness, prevention and providing the highest quality medical services possible for Carroll, Gallatin and Owen Counties.

Triad Health Systems, Inc. and its clinics are a Health Center Programm grantee under 42 U.S.C. 254b, and a deemed Public Health Service employee under 42 U.S.C. 233(g)-(n).

HISTORY

Triad Health Systems, Inc. was created in 2008 to provide medical services to all residents of the service area with emphasis on the un-insured and under-insured residents. The service areas include Carroll, Gallatin and Owen Counties. Services are provided in collaboration with area agencies, organizations and health care providers. Triad added Mental/Behavioral Health Services and Optometry Services in 2015 and dental services in 2017.

MEDICATION REFILLS

- Call pharmacy at least 3 business days before you need your medications.
- Indigent Refills-You must call when you have 30 days' worth of medications left. Please do not wait until you are out, it can take 3-4 weeks for these medications to arrive.

CANCELLATION/NO-SHOW POLICY

- Please call 24 hours before your scheduled appointment to cancel.
- Same day cancellations are considered a No-Show.
- If you have multiple No-Show appointments, then you will be put on Work-In status. You will not be given an appointment. You will have to arrive at 8am or 1pm and wait until one of the providers can work you into the schedule. You will not be able to pick which provider.

TRIAD Health Systems Inc.

Patient Handbook

PROMOTING WELLNESS, PREVENTION & QUALITY MEDICAL SERVICES

Serving Carroll, Gallatin, & Owen Counties

Carrollton Office Hours:
Mon-Fri 8 am – 5 pm

Warsaw Office Hours:
Mon - Fri 8 am – 5 pm

Owenton Office Hours:
Mon - Fri 8 am – 4:30 pm

Dental Office Hours:
Mon & Wed 7 am – 5:30 pm
Tues & Thur 7 am – 5:00 pm

Behavioral Health:
(all locations)
Mon - Fri 8 am – 5 pm

COMPLIMENTS, CONCERNS, GRIEVANCES

- Ask front desk staff for a form to complete.
- Call or ask to talk to a Clinic Manager.

Patient Responsibilities

- Arrive on time for appointments.
- Call if you will be late or need to reschedule.
- Bring all medication bottles to the appointment.
- Bring copay for appointment. Copays have to be paid the day of your appointment.
- Complete all paperwork in full. We may not be able to provide adequate care if we do not have all pertinent information.
- Inform clinic of any new insurance, phone numbers or addresses.
- Be considerate and cooperative with staff and respect the rights of fellow patients.
- Ask questions and to seek clarification necessary to adequately understand your illness.
- Weigh the potential consequences of any refusal to comply with instructions or recommendations of your health care provider.
- Express opinions, concerns, or complaints in a constructive manner.
- Ensure that all information provided for inclusion in your medical record is complete and accurate.

Sliding Fee Scale and Billing

ALL SLIDING FEE SCALE PAPERWORK MUST BE COMPLETED BEFORE ANY TYPE OF DISCOUNT WILL BE APPLIED TO YOUR BILL.

PRESUMPTIVE (ESTIMATED) ELIGIBILITY IS FOR FIRST VISIT ONLY.

IF ALL PAPERWORK IS NOT COMPLETE, YOU WILL HAVE TO PAY THE FULL CHARGE FOR ALL FOLLOW-UP VISITS INCLUDING LABS, SHOTS, AND/OR TESTING BEFORE THE SERVICES WILL BE PERFORMED.

Reviewed/Revised: 05/17/2022 (THS-070C)

Medical/Mental Health/Optometry
*Except for Glasses or Contacts

If your percentage rate is:	Percentage/Amount of Total Charges you will pay:
Full Slide - 100% Discount	Nominal Fee: Medical/Mental Health First Visit -$15.00 Follow up Visits -$15.00 $5.00 Each Lab/Shot/Test
75% Discount	25%
50% Discount	50%
40% Discount	60%
No Discount/Self Pay	100%
If you are No Discount/Self Pay, you may receive a discount if all charges are paid at time of service.	70% if paid for everything at time of service

Dental *Except for Denture, Partials,

If your percentage rate is	Percentage/Amount of Total Charges you will pay
Full Slide - 100% Discount	Nominal Fee: First Visit -$20.00 Follow up Visits -$20.00
75% Discount	25%
50% Discount	50%
40% Discount	60%
No Discount/Self Pay	100%
If you are No Discount/Self Pay, you may receive a discount if all charges are paid at time of service.	70% if paid for everything at time of service

***For Pricing on Dentures, Partials, Crowns, etc., Please contact the Dental Office. Sliding Fee Scale must be completed to get correct pricing.**

Glasses or contacts are though Dr. Metzger.

Sliding Fee Scale (SFS) cont.

Your percentage is determined by your household size* and total household income**. The total charge for your visit is determined by adding the office visit charge and all other charges for services that were ordered during your visit. Other charges may include lab tests, immunizations or injectable medications. You will be billed according to your qualified percentage rate. If your total charges are more than the amount you paid at the time of service, you will be billed for the remaining balance. Monthly payments must be paid on all remaining balances until balance is paid in full.

*Household size, as referenced in the SFS Policy, is defined as the total of all persons living at the address of the person making application to the SFS program. If the applicant is living in a group home, household size will be one (other residents of the group home will not be included).

**Household income is defined as the total income of all persons living at the address of the person making application to the SFS program. If the applicant is living in a group home, only the income of the applicant will be included.

Proof of Income may include:

1. A current pay stub.
2. Most recent income tax return (must be less than 2 yrs old).
3. Annual Award Statement from Social Security.
4. Social Security, Disability SSI, or Pension as documented in the applicant's or other household member's most recent bank statement.
5. Employer letter pertaining to applicant or other household member.
6. Qualification letter from the Food Stamp Office.
7. A letter of stating amount of support from another person that is providing support to the applicant. Any combination of the above may be used to verify the income of individual members of the household.

Self-pay patients may receive an estimate for charges of scheduled visits if scheduled prior to 24 hours ahead of time. Any estimates for a scheduled visit will not include any items/services provided during the visit. See: **45 CFR Part 149-610, No Surprises Act, Title I, Section: Good Faith Estimate**

Medical Services AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, _____, _____
(Full Name of Client) (S.S. No. /I.D. No.) (Date of Birth)

authorize and give this consent voluntarily. I have been informed of the specific type of information that is being requested/released. I also understand that refusal to sign this authorization in no way affects my treatment, payment or eligibility for benefits. I understand that I may inspect or copy my records prior to use or disclosure. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of any health information, I can contact the Privacy Officer at Triad Health Systems, Inc. (THS)

CHECK APPROPRIATE BOX BELOW:

☐ **FROM THS to name identified below** ☐ **FROM name identified below to THS** ☐ **TO/FROM name identified below and THS**

Complete address for THS:

Triad Health Systems, Inc.

_____

_____

Fax/Phone #: _____

Complete address for individual name/other agency:

_____

_____

_____

Fax/Phone #: _____

« « « « « « » » » » » »

TYPE OF INFORMATION TO BE RELEASED: (Check all that apply):

___ Progress Notes
___ Laboratory/Pathology
___ X-Rays/Radiology Records
___ Medication Flow Sheet
___ Mammogram ___ Colonoscopy
___ Other (Specify)_____

___ Diagnostic Testing
___ Referral Sheets/Information
___ Immunization Record
___ Entire record
___ Pap Smear results

PURPOSE FOR RELEASE:

___ Continued Medical Care
___ Disability
___ Transfer to other PCP
___ Accompany client to appointments
___ Other (Specify)_____

___ Personal Interest
___ Specialist Appointment
___ Attorney/Legal Purposes

SUBSTANCE ABUSE/HIV/AIDS/STD INFO TO BE RELEASED

Medical records may contain info from previous providers or info about HIV/AIDS status diagnosis, sexually transmitted disease or drug/alcohol abuse diagnosis.

Please EXCLUDE the following information if it is a part of my Medical Record (check below any or all you want to exclude for use or disclosure):

___Chemical Dependency/Substance Abuse ___Sexually Transmitted Diseases
___Psychiatric/psychological Conditions ___Alcohol ___Drugs

NOTE: Records for THS Behavioral Health Services must complete a BH release.

AMOUNT OF INFORMATION TO BE RELEASED:

___ Information covering the most recent visit
___ Information from beginning to present
___ Information covering the previous two years
___ Other time frames (specify to/from dates)_____

LIMITATION OF RELEASE:

This authorization will expire in 120 days from the date signed (unless otherwise revoked) or if specified on the following date: _____

« « « « « « » » » » » »

PROHIBITION ON REDISCLOSURE:

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by Federal Regulations. The general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

REVOCATION OF RELEASE:

This release is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. **For the revocation of this authorization to be valid a "Release Revocation" form must be completed in writing, a proper photo I.D. provided and signed by patient or legal representative/guardian.** ***Compliance Officer must be notified if a revocation release if completed.***

« « « « « « » » » » » »

_____ _____
Signature of Client Date

_____ _____
Signature of Client's Parent/Legal Guardian Date

_____ _____
Witness Date

****

STAFF INSTRUCTIONS: All INFORMATION ON THIS PAPER must be entered electronically and/or scanned into the patient record as soon as possible. This release of information must have the witness signature to be valid. Records for THS Behavioral Health Services must complete a BH release.

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Telehealth services and what you need to know.....

Trying out a new way to see your Provider can be a little scary. We're talking about your mental and health care after all. What could be more important than that? It's worth taking the time to explain the details of Telehealth services and answer any questions that our patients may have. We feel that once our patients get comfortable with this new approach, you will enjoy all the benefits this approach will offer you.

Basically, Telehealth means conducting visits using audio and video over the internet, rather than meeting in person. We will schedule a video visit with you. You'll open an application that has been designed specifically for this purpose, on your smartphone, tablet or computer that has high-speed internet access and a camera. The Provider will open the application on their end, and you will be able to talk to and see each other. You can be anywhere with a good internet connection and enough privacy.

Benefits of Telehealth

A few key benefits of seeing a provider through Telehealth are:

- **No transportation time or costs** – When you see your Provider on your mobile device or computer, you can save money on gas, parking, and public transportation.
- **No need to take time off work** – You can schedule your appointment during a break, or before or after work (depending on provider's work schedule). You can do the visit from anywhere that you feel offers you enough privacy. There's no need to waste your paid time off.
- **Eliminate child or elder care issues** – If you have the responsibility for caring for children or older adults, finding someone to fill in can be a challenge, as can bringing them along. Telehealth services lets you see your Provider while managing your family responsibilities.
- **Less exposure to illness** – With a video visit, there's no chance that you'll catch something from another patient such as flu during flu season.
- **Improved health outcomes** – When you are able to see us as often as you need to you put yourself on the path to better health.

Privacy and Security of Telehealth

Patients are right to be concerned about the privacy and security of their confidential health information. While today's digital world offers a lot of convenience, there are risks. We want to ensure you that we are using a Telehealth software application that is designed specifically to protect patient information and meet the strictest standards possible that allows for encryption during the telecommunications for a secure communication between Patient and Provider.

Maintaining client confidentiality is vitally important to our Providers and the Providers will take extraordinary care and consideration to prevent unnecessary disclosure. Further information is provided in our Notice of Privacy Practices on how we maintain and secure your protected health information.

- Like in-person treatment, the Provider will maintain visit notes of online services that are consistent with in-person treatment standards. Although, we do not currently do any audio or video recordings for any visits, if we should in the future for any reason, the patient will be asked in advance for permission to do so.

Insurance Coverage for Telehealth

Insurance Coverage concerns:

- **You will want to know if telemedicine is covered by insurance** - The office will verify eligibility for Telehealth services before the visit.
  - If the visit is approved, it will not cost the patient anything more than an in-person visit would under their coverage.
  - For patients who do not have private insurance, Medicaid or Medicare, we offer the patient the Sliding Fee Scale Program, just discuss this with office staff when you call in for an appointment, they will be happy to assist you with this.

Limitation of Telehealth

Some limitations of using technology in Telehealth are:

- **Not Identical to In-Person Experience** - Video conferencing technology has advanced over the years and now enables two people to interact face-to-face online in a way that closely approximates being in the same room. However, due to webcams never being physically placed exactly where one is looking on the screen there is usually a slight mismatch between where one is looking and what the other person is seeing. So, this can make eye contact feel a little different at first when interacting via two-way video counseling.
- **Different Logistical Requirements** - When you physically come to the office this requires you to navigate traffic, locate the building, etc. When you have an online Telehealth service the logistical requirements are different. You need to provide for yourself a private space, free of distractions where you can have your Telehealth service. You also need to be at least somewhat comfortable with using technology (e.g., logging into a website, interacting via webcam, etc.).
- **Different Potential for Interruptions** - With Telehealth services there is some potential for interruption, and though the frequency of interruptions is typically low, there is the possibility that an interruption in an online service could be longer than a minute or two. This is because the online services are dependent on both the patient's and the Provider's internet connections as well as each person's computer working well. If either person's internet connection is temporarily disconnected, or either person's computer freezes or crashes, then the online service will be interrupted. In the event of a technical interruption that lasts more than several minutes, a phone contact will be made.
- **Less Suitable for Some Medical and/or Counseling Needs** – Medical visits needing injections, breathing treatments, etc., cannot be completed by Telehealth services. Also, Distance Counseling by Telehealth is less ideal than in-person visits for some counseling goals. For example, with couple's counseling it can be challenging for more than one client (i.e., the couple) to share the same webcam.
    - Distance Counseling is not suitable for individuals who are actively making attempts to take their own life (i.e., are actively suicidal).

Risks During the Use of Telehealth

Potential risks in the use of Telehealth:

- **Misunderstandings** - It is important to be aware that there is an increased risk for misunderstanding when using telephone, text-based modalities such as email, real-time internet chat, or video conferencing since many of the non-verbal cues are significantly reduced. When using video conferencing software, misunderstandings may occur since bandwidth is always limited and images can lack detail. If you have never engaged in Telehealth services before, please have patience with the process and provide clarification if you think your Provider has not fully understood you. We also ask that you be patient if your clinician periodically asks for clarification as well.
- **Privacy** - Although the internet provides the appearance of anonymity and privacy in Telehealth services, privacy during Telehealth services can present with some unique challenges. The patient is responsible for securing their own computer hardware, internet access points, chat software, email and passwords. The Provider has a right to his or her privacy and may wish to restrict the use of any copies or recordings the client makes of their communications. Patients must seek the permission of the Provider before recording any portion of the session and/or posting any portion of said sessions on internet websites such as Facebook or YouTube.
- **Other risks to consider** - These risks may include: (1) email messages not being received if email is used; (2) possible denial of insurance benefits; and (3) confidentiality being breached through unencrypted email, lack of password protection or leaving information on a public access computer in a library or internet café. Messages could fail to be received if they are sent to the wrong address (which might also be a breach of confidentiality). Confidentiality could be breached in transit by hackers or Internet service providers or at either end by others with access to the computers. People accessing the internet from public locations such as a library, computer lab or café should consider the visibility of their screen to people around them. Position yourself to avoid peeping by those around you. Using cell phones can be risky in that signals are scrambled but rarely encrypted.

DISCONNECTION DURING TELEHEALTH:

- Disconnection of Services - If there is ever a disruption during the Telehealth service and reconnection is not possible, a THS employee and/or the Provider will contact the patient by phone. The THS employee and/or Provider will make the decision to do one, or more, of the following:
    - Continue addressing the concern with the patient, if possible.
    - Schedule an appointment for a face-to-face service for the next available time.
    - Have patient to contact 911 or go directly to the hospital, if assessment warrants this.

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TELEHEALTH INFORMED PATIENT CONSENT

Patient Name: _____ DOB: _____

A "Telehealth" service involves the use of electronic communications to enable Triad Health Systems, Inc. (THS) Medical and Behavioral Health Providers to connect with individuals using interactive video and audio communications. Telehealth is performed from one site to another via electronic communications. Telehealth includes the practice of a health care delivery, assessment, diagnosis, consultation, treatment, referral to resources and education for medical and behavioral health patients.

Technology: I understand that I will need to download an application and/or software to use this platform. I also need to have a broadband Internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. I also understand that in case of technology failure, I may contact THS Provider/staff via phone to coordinate alternative methods of treatment.

Financial Obligations: Fees associated with telehealth appointments are payable by credit or debit card only if fees are associated with my telehealth services. Payment is expected before my Telehealth service is provided and/or payment arrangements is made before the Telehealth service. My card will be billed the same day as my scheduled telehealth appointment. If my card is declined, THS will cancel my appointment and I will be charged in accordance with the cancelation policy.

Clients using insurance: I am responsible for contacting my insurance company, if applicable, to determine what my cost and/or out-of-pockets costs may be. I authorize insurance benefits to be paid directly to Triad Health Systems, Inc. and that THS may release any information to my insurance provider required for processing my claims. I understand that I am responsible for cancelled telehealth appointments in accordance with the THS cancellation policy as documented by my signature on the Informed Consent.

Self-Pay clients: I am aware of the fees associated with telehealth appointments and agree to pay at the time of my appointment. I understand that I am responsible for cancelled telehealth appointments in accordance with the THS cancellation policy as documented by my signature on the Informed Consent.

Scheduling: I understand that scheduling is conducted through the THS office and is based on my provider's normal clinic hours. I understand I must schedule my appointment the same way I currently schedule an appointment by contacting the office. Telehealth appointments are considered outpatient services and not intended as a substitute for emergency or crisis services. Medical or crisis/behavioral health emergencies should be directed to the local crisis line or by dialing 911.

Video/Audio Recording: As a general practice, Triad Health Systems, Inc. Medical and/or Behavioral Health services DOES NOT record Telehealth services without prior permission.

Confidentiality: The laws that protect the confidentiality of my medical and behavioral health information also apply to Telehealth information. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. THS Telehealth platform is HIPAA compliant to protect my privacy and confidentiality. This is further explained in the in the patient "Notice of Privacy Practices", which I have signed.

I understand that I have the following rights with respect to Telehealth Services:

1. I have the right to withdraw my consent to the use of telehealth services at any time during my treatment without affecting my right to future care or treatment. I must contact the THS office to notify my provider and/or THS staff of my withdrawal.
2. I understand that there are risks and consequences associated with Telehealth service including, but not limited to the possibility, despite reasonable efforts on the part of my provider, that the transmission of my health information could be disrupted or distorted by technical failures. In addition, I understand that telehealth-based services and care may not be as complete as face-to-face services. THS utilizes secure, encrypted audio/video transmission software to deliver Telehealth Services.
3. I also understand that if my provider believes I would be better served by another form of medical or psychotherapeutic services (e.g. face-to-face services) I will be referred to a medical or behavioral health provider who can provide such services in my geographic area.
4. **I understand it is my responsibility to maintain privacy on my (the patient) end of communication if Telehealth services are being provided two-way from the provider and patient's home and/or other location besides a THS site. I will take all precautions to ensure that my communications are directed only to my provider.**
5. I understand that I may benefit from Telehealth, but results cannot be guaranteed or assured.
6. I understand that THS Providers may not provide Telehealth services to me if I am outside the State of Kentucky. If this is the case, THS staff will notify you of this before you are seen.
7. I understand that I have a right to access my health care information and copies of medical records in accordance with HIPAA laws.
8. I will be informed of any other people who are present at either end of the Telehealth service and have the right to exclude anyone from either location. The Provider has a right to his or her privacy and may wish to restrict the use of any copies or recordings the client makes of their communications. Patients must seek the permission of the Provider before recording any portion of the session and/or posting any portion of said sessions on internet websites such as Facebook or YouTube.
9. If an emergency occurs during a telehealth encounter at a clinic office, health care personnel at the location will manage the emergency. **If an emergency occurs during a telehealth encounter when I am at a non-health-care site, I should call 911 and stay on the video connection (if applicable) until help arrives.**

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☐ **I hereby consent to engage/opt-in to Telehealth Services** at Triad Health Systems, Inc. (THS) as part of my medical and/or behavioral health treatment.

☐ **I choose to opt out and/or decline participation in Telehealth Services at this time.**

I have read and understand the information provided above regarding Telehealth Services. I have discussed it with my THS provider and all my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment using this Telehealth platform.

_____ _____

Patient Signature: Date:

_____ _____

Patient/Legal Guardian/Representative's Signature: Date:

_____ _____

Witness Signature: Date:

NO SURPRISE ACT - GOOD FAITH ESTIMATE

YOU HAVE THE RIGHT TO RECEIVE A "GOOD FAITH ESTIMATE"
EXPLAINING HOW MUCH YOUR MEDICAL CARE WILL COST

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** (paying full cost) an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services **within 3 business days of the appointment if the appointment is scheduled 10 business days in advance.** This can include related costs to services like medical tests, prescription drugs, equipment and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service if scheduling an appointment within 9 days in advance or if you requested a Good Faith Estimate without scheduling, 3 days after request. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or contact the Billing Department at: Dean Dorton Health Solutions at 502-916-3158. **For disputes**, you may request a Complaint Form from the office to start the dispute process if you feel you was charged for more than the amount given to you on the Good Faith Estimate for a service(s) that was provided to you by Triad Health Systems, Inc.

What are the new protections?

For consumers who get coverage through their employer (including a federal, state, or local government), through the Health Insurance Marketplace® or directly through an individual health plan, beginning **January 2022**, these rules will:

- Ban surprise billing for emergency services. Emergency services, even if they're provided out-of-network, must be covered at an in-network rate without requiring prior authorization.
- Ban balance billing and out-of-network cost-sharing (like out-of-network co-insurance or copayments) for emergency and certain non-emergency services. In these situations, the consumer's cost for the service cannot be higher than if these services were provided by an in-network provider, and any coinsurance or deductible must be based on in-network provider rates.
- Ban out-of-network charges and balance billing for ancillary care (like an anesthesiologist or assistant surgeon) by out-of-network providers at an in-network facility.
- Ban certain other out-of-network charges and balance billing without advance notice. Health care providers and facilities must provide consumers with a plain-language consumer notice explaining that patient consent is required to get care on an out-of-network basis before that provider can bill the consumer.

For consumers who don't have insurance, these rules make sure each individual knows how much their health care will cost before they get it, and might help if the patient receives a bill that's larger than expected. For further information on payment disputes between uninsured or self-pay consumers and providers, go to: https://www.cms.gov/nosurprises/consumers/payment-disagreements

The rules don't apply to people with coverage through programs like Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE because these programs have other protections against high medical bills.

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Triad Health Systems Guidelines for Controlled Medications

Due to Federal and State guidelines, Triad Health Systems began a policy as of January 1, 2020 with the intent to address the use of long term and chronic controlled medications in the population receiving treatment by way of Triad Health Systems.

Therefore, if you are on any controlled medications which were started by a non-Triad provider, including but not limited to: narcotic pain medications (hydrocodone, oxycodone, tramadol, etc.), sleeping aids such as Ambien, medications for anxiety such as Klonopin/Xanax/Valium/etc. or others in the category of controlled medications, Triad providers will most likely not continue or take over prescribing these medications. In addition to the categories listed above, other controlled medications such as stimulants, gabapentin (Neurontin), muscle relaxers (e.g. Soma), barbiturates, and others, may not be continued as well.

We may be able to help you transition away from these medications, with a weaning period not to exceed two months, but again, there is no guarantee these medications will be continued by a Triad provider. If a two-month weaning period is agreed upon, and you are unable to transition off the medication by the end of two months, you will be asked to seek continuing treatment via another system of care which may allow continuation of the medication in question. This information is provided to you before entering treatment at Triad so that you are aware of our agency's approach to these medications.

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Please sign and date that you are aware of this policy and understand our guidelines regarding controlled medications.

Patient or Parent/Guardian Signature: _____

Date: _____

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