NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

River Hills Community Health Center takes its obligations and responsibilities regarding the protection of the privacy and confidentiality of your personal medical information very seriously. Our Notice of Privacy Practices describes when we are required by law to disclose your medical information. Our Notice of Privacy Practices also describes when we may disclose your medical information unless you inform us otherwise. And our Notice of Privacy Practices describes your rights regarding the protection of your personal medical information.

Effective Date: 9/23/13
This Notice was revised on 9/14/17

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer: Michelle Bowers
Mailing Address: PO Box 458, Ottumwa, IA 52501
Telephone: 641 – 954 - 9971
Fax: 641 – 954 - 9975
Email: mbowers@riverhillshealth.org

About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information. This Notice explains your rights and our obligations and we are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

"Protected Health Information" is information that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse that identifies you and relates to (1) your past, present, or future physical or mental health or conditions, (2) the past, present, or future payment for your health care or (3) the provision of health care to you. "Protected Health Information" is sometimes referred to as PHI or EPHI (electronic protected health information).

How We May Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information in the following circumstances:

- **For Treatment.** We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician, other health care providers, or other health care facilities to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service. We will also share health information about you with nurses, physicians, students, and others who are involved in your care. These individuals will also be able to view your health information in our electronic medical record system.

- **For Payment.** We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment. We may also disclose health information about you to other health care providers, health plans, and health care clearing houses for their payment purposes. Your account may be referred to a collection company if you fail to pay for services provided. The confidentiality of your information cannot be guaranteed if your account is referred to small claims court as part of this process.

- **For Health Care Business Operations.** We may use and disclose your Protected Health Information for our health care business operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, students, and other authorized personnel for educational and learning purposes.

- **Appointment Reminders.** We may use and disclose your Protected Health Information to contact you to remind you that you have an appointment for medical care.

- **Treatment Alternatives/Health-Related Benefits and Services.** We may contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

- **Completely De-Identified or Partially De-Identified Information.** We may use and disclose your health information if we have removed any information that has the potential to identify you, so that the health information is "completely de-identified". We may also use and disclose "partially de-identified" health information about you for certain purposes if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified information will not contain any information that would directly identify you.

- **Incidental Disclosures.** While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of your health information.

- **Minors.** We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

- **Research**. We may use and disclose your Protected Health Information for research purposes under certain circumstances and subject to certain safeguards. For example, we may disclose information to researchers when their research has been approved by a special committee that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

- **As Required by Law.** We will disclose your Protected Health Information about you when required to do so by law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose your Protected Health Information if we, in good faith, believe the use or disclosure is necessary to prevent or lessen a serious threat to your health or safety or to the health or safety of others or is necessary for law enforcement authorities to identify or apprehend an individual involved in a crime.

- **Business Associates.** We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.

- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or

transplantation as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may disclose Protected Health Information as required by military command authorities. We also may disclose Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.

- **Workers' Compensation.** We may use or disclose your Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

- **Employers.** We may disclose your Protected Health Information to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a written authorization for the release of that information to your employer.

- **Public Health Risks.** We may disclose your Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect or dependent adult abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- **Abuse, Neglect, or Domestic Violence.** We may disclose Protected Health Information to the appropriate government authority if we believe an individual has been the victim of abuse, neglect, or domestic violence.

- **Health Oversight Activities.** We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or

other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.

- **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes, such as:

    - Reporting certain wounds and physical injuries
    - In response to a court order, subpoena, warrant, summons, or similar process
    - To identify or locate a suspect, fugitive, material witness, or missing persons
    - To alert authorities of a death we believe may be the result of criminal conduct
    - Information we believe is evidence of criminal conduct occurring on our premises
    - To report a crime; the location of the crime or victim or identity, description or location of the person who committed the crime
    - In emergency situations

- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.

- **Deceased Individuals**. We may disclose your Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties. Following your death, unless you have expressed a contrary preference, we may disclose health information about you to a personal representative (for example, the executor of your estate) or to a family member or other person who acted as a personal representative or was involved in your care or payment for care before your death, if the health information about you is relevant to such person's involvement in your care or payment for your care. We are required to apply safeguards to protect your health information for 50 years following your death.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

- **Health Information Exchange.** We participate in one or more electronic health information exchanges which permits us to exchange health information about you with other participating providers (for example doctors, nurses and hospitals) and their business associates. For example, we may permit a physician providing care to you to access our records in order to have current information with which to treat you. In all cases, the requesting provider must verify that they have or have had a treatment relationship with you. If required by law, we will ask the provider to obtain your consent before accessing your health information through the health information exchange. Participation in a health

information exchange lets us access health information about you from other participating providers and health plans for our treatment, payment and health care operations purposes. We may in the future allow other parties, for example, public health departments that participate in the health information exchange, to access your health information for their limited uses in compliance with federal and state privacy laws such as to conduct public health activities.

- **Iowa Health Information Network (IHIN).** We are participating in the Iowa Health Information Network (IHIN) which is the state of Iowa's health information exchange. Iowa law provides that health information, including mental health treatment records and HIV/AIDS testing, may be shared between providers through the IHIN for treatment purposes without patient consent. If you do not want to have your health information shared with providers through the IHIN, you may contact the Iowa Department of Public Health or our Privacy Officer to obtain information on how you can opt out of the IHIN.

- **Organized Health Care Arrangement.** From time-to-time we may refer our patients for medical care and treatment to a hospital to be cared for by independent providers who have hospital privileges at the receiving hospital. These providers will need to access your health information in order to provide care to you. In these instances these providers have agreed to follow uniform information practices when using or disclosing health information related to inpatient or outpatient hospital services. This arrangement is called an "Organized Health Care Arrangement" (OHCA) and covers information practices for services rendered by providers who work at the hospital. It does not cover the information practices of the providers in their private offices or at other care settings. It does not alter the independent status of the hospital or the hospital medical staff members or make them jointly responsible for the clinical services provided by them.

<u>Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out</u>

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

- **Disaster Relief.** Unless you object, we may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

- **Fundraising Activities.** Unless you object, we may use or disclose your Protected Health Information in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. If you do not want to receive these materials, please submit a written request to the Privacy Officer.

- **Disclosure of Immunization Records.** Unless you object, we may disclose proof of immunizations for a student or prospective student directly to a school.

Your Written Authorization is Required for Other Uses and Disclosures

Some kinds of information are considered so sensitive that state or federal laws provide special protections for them. Except as may otherwise be described in this Notice, the following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Most uses and disclosures of psychotherapy notes;
2. Information about substance abuse treatment;
3. Information about genetic testing or the results of genetic testing;
4. Uses and disclosures of Protected Health Information for marketing purposes; and
5. Disclosures that constitute a sale of your Protected Health Information.

While your written authorization will generally be required before we may disclose these types of information, some exceptions apply. For example, your written authorization is not required for your therapist to use psychotherapy notes to treat you, or to disclose them to others in the course of your treatment or training programs, or for legal defense in an action you bring, or for oversight by the therapist or by an authorized government agency, or as otherwise required by law.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to the Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosures made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy.** You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. All requests for access must be made in writing. We have up to 30 days to make your Protected Health Information available to you. We may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. If you are a parent or legal guardian of minor, certain portions of the minor's medical record may not be accessible to you under Iowa law.

  We may deny your request in certain limited circumstances.

- **Right to a Summary or Explanation.** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an

explanation of the Protected Health Information which has been provided to you, so long as you agree to this alternative form and pay the associated fees.

- **Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

- **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information. We will provide such notice to you without unreasonable delay but in no case later than 60 days after we discover the breach.

- **Right to Request Amendments.** If you feel that the Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request.

  We will respond to your request within 60 days. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay and when you can expect to have a final answer to your request.

  In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes, incidental disclosures, disclosures for research, public health, or our business operations, disclosures made to federal officials for national security and intelligence activities, or disclosures about inmates to correctional institutions or law enforcement officers. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records.

  The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs

of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

We will respond to your request within 60 days. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay and when you can expect to have a final answer to your request.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.

- **Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your provider directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

We may change the terms of this notice at any time. If we change this notice, we may make the new notice terms effective for all health information that we hold, including any information created or received prior to issuing the new notice. If we change this notice, we will post the revised notice in our practice areas and on our website. You may also obtain any revised notice by contacting the Privacy Officer.

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.

RIVERHILLS
COMMUNITY HEALTH CENTER
Diversified Services · Exceptional Healthcare

Patient Registration Form

Attachment B

ATTENTION: Please provide copies of insurance cards at time of registration. If you do not have insurance or need assistance in paying for services, you will need to complete a Sliding Fee Application which is available at the front desk.

Patient Information

Last Name_____ **First Name**_____ **MI**____ **Soc. Sec. #** ___-___-___

Address_____ **City**_____ **State**_____ **Zip**_____

County_____ **Date of Birth**_____ **Gender:** ☐Male ☐Female

Home Phone #_____ **Cell Phone #**_____ **Email**_____

May We Leave Messages regarding the following:

Appointments, pre-medication and instruction appointments? ☐Yes ☐No

Medical or Dental information? ☐Yes ☐No

Information about our Sliding Fee Discount Program? ☐Yes ☐No

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Employment Status: ☐Full-time ☐Part-time ☐Self-employed ☐Retired ☐Unemployed

Student Status: ☐Full-time ☐Part-time ☐N/A **Military Status:** ☐Active ☐Retired ☐Veteran ☐N/A

Race (Please choose one): ☐White/Caucasian ☐Asian ☐Black/African American ☐American Indian/Alaskan Native ☐Other Pacific Islander ☐Native Hawaiian

Ethnicity (Please choose one): ☐Hispanic/Latino ☐Non-Hispanic or Latino

Primary Language: ☐English ☐Spanish ☐Other_____ **Are Interpretation Services Needed?** ☐Yes ☐No

Employer:_____ **Occupation:**_____

Do you currently receive public housing? ☐Yes ☐No

Emergency Contact_____ **Relationship**_____ **Phone #**_____

Responsible Party (parent/guardian/person who will pay the bill). If patient is responsible party, skip this section.

Last Name_____ **First Name**_____ **MI**____ **Soc. Sec. #** ___-___-___

Address same as Patient ☐ **If Not: Address**_____ **City**_____ **State**_____ **Zip**_____

County_____ **Date of Birth**_____ **Gender:** ☐Male ☐Female **Phone #**_____

Insurance Policyholder: ☐Yes ☐No **Employer**_____

Patient's Relationship to Responsible Party:

☐Spouse ☐Child ☐Foster Child ☐Grandchild ☐DHS Custody ☐Other_____

Insurance Information

Primary Insurance_____

Last Name_____ **First Name**_____ **Soc. Sec. #** ___-___-___

Address same as Patient ☐ **If Not: Address**_____ **City**_____ **State**_____ **Zip**_____

Date of Birth_____ **Gender:** ☐Male ☐Female **Phone #**_____ **Employer**_____

Secondary Insurance_____

Last Name_____ **First Name**_____ **Soc. Sec. #** ___-___-___

Address same as Patient ☐ **If Not: Address**_____ **City**_____ **State**_____ **Zip**_____

Date of Birth_____ **Gender:** ☐Male ☐Female **Phone #**_____ **Employer**_____

Continue on back →

Living Situation

Do you consider yourself homeless? ☐Yes ☐No

If yes, what definition would best describe your living situation?

☐Shelter ☐Street ☐Doubled Up (Temporarily living with others.)

☐Transitional Housing (Temporary housing and supportive services to transition from homeless to permanent housing.)

☐Other (Single room occupancy hotels/motels, day to day paid for housing, etc.) _____

Notice Of Privacy Practices Acknowledgement

I understand that, under HIPAA laws, I have certain rights to privacy regarding my health information. I understand that this information can and will be used for: Treatment, Payment, and Healthcare Operations. I have received, read and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

X _____ _____ _____

Patient or Responsible Party Signature *Relationship to Patient* *Date*

HIPAA Approved Contacts

I hereby give permission to River Hills Community Health Center to disclose health and/or billing information to the individuals identified below that are involved in my care or payment of care.

Name_____ **Relationship**_____ **Phone #**_____

Name_____ **Relationship**_____ **Phone #**_____

Please Select Your Household Size and Your Estimated Yearly Gross Household Income:

Household Size	Yearly	Yearly	Yearly	Yearly	Yearly
1	☐0-$12,060	☐$12,061-$16,884	☐$16,885-$20,904	☐$20,905-$24,120	☐$24,121+
2	☐0-$16,240	☐$16,241-$22,736	☐$22,737-$28,149	☐$28,150-$32,480	☐$32,481+
3	☐0-$20,420	☐$20,421-$28,588	☐$28,589-$35,395	☐$35,396-$40,840	☐$40,841+
4	☐0-$24,600	☐$24,601-$34,440	☐$34,441-$42,640	☐$42,641-$49,200	☐$49,201+
5	☐0-$28,780	☐$28,781-$40,292	☐$40,293-$49,885	☐$49,886-$57,560	☐$57,561+
6	☐0-$32,960	☐$32,961-$46,144	☐$46,145-$57,131	☐$57,132-$65,920	☐$65,921+
7	☐0-$37,140	☐$37141-$51,996	☐$51,997-$64,376	☐$64,377-$74,280	☐$74,281+
8	☐0-$41,320	☐$41,321-$57,848	☐$57,849-$71,621	☐$71,622-$82,640	☐$82,641+
9	☐0-$45,500	☐$45,501-$63,700	☐$63,701-$78,867	☐$78,868-$91,000	☐$91,001+
10	☐0-$49,680	☐$49,681-$69,552	☐$69,553-$86,112	☐$86,113-$99,360	☐$99,361+
11	☐0-$53,860	☐$53,861-$75,404	☐$75,405-$93,357	☐$93,358-$107,720	☐$107,721+
12+	☐0-$58,040	☐$58,041-$81,256	☐$81,257-$100,603	☐$100,604-$116,080	☐$116,081+

Payment Agreement: I hereby certify that the above information is true. I understand that I am expected to promptly and fully pay for services provided by River Hills Community Health Center according to the fees established including co-pays and deductibles.

Assignment of Benefits: I hereby assign and authorize direct payment to River Hills Community Health Center of all insurance coverage or other benefits under any government program, any insurance policy or plan, or any other available benefit. This assignment shall remain in effect until revoked in writing.

Consent to Medical Treatment: I hereby request and give consent for the health care professionals at River Hills Community Health Center to provide medical treatment to me and/or my family.

Consent to Dental Treatment: I hereby request and give consent for the dental care professionals at River Hills Community Health Center to provide dental treatment to me and/or my family to include exam, radiographs, prophylaxis and application of fluoride.

Consent to Release Protected Health Information: I authorize River Hills Community Health Center to release medical information relating to the patient to health insurance companies, health plans or third party payors, or their authorized agents, for the purpose of determining benefits payable in connection with services provided.

X _____ _____ _____

Patient or Responsible Party Signature *Relationship to Patient* *Date*