**Center Street Community Health Center Corporate Office - Notice of Rights and Responsibilities**

We are committed to offering each patient a personal provider to coordinate all healthcare needs in multiple settings. Patients can expect evidence-based, high-quality preventative and primary health care from their clinician and team, as well as patient-focused support for self-management health care.

Patients of **Center Street Community Health Center** in Marion, Ohio may request care and advice by calling 740-751-6380 between the hours of 8:00a.m. and 4:30 p.m., Monday –Friday.
**Patients requiring advice after office hours are instructed to call the after-hours answering service at 740-383-8400.**

Patients of **Morrow Family Health Center** in Mt. Gilead, Ohio may request care and advice by calling 419-751-9010 between the hours of 8:00a.m. and 4:30 p.m., Monday –Friday.
**Patients requiring advice after office hours are instructed to call the after-hours answering service at 740-383-8400.**

Assistance for our Behavioral Health patients can also be found by calling the national suicide prevention, "LIFELINE" at 1-800-273-TALK (8255) or "Contact Care-Line" at 740-383 CARE (2273).
You can also go directly to a hospital emergency room or call 911.

## Patient No-Show Policy

Patients who do not attend a scheduled appointment and do not give notice of cancelation will be considered a "No Show". Any patient that is a no-show to three appointments in a calendar year will be seen on a walk-in basis only. Patients may arrive to the center during regular scheduled provider hours and wait for an open appointment. If an appointment time opens, the patient can be added to a provider's schedule.

**There is no guarantee an appointment time will become available, nor is there an estimated wait time.**

## Zero Tolerance

Center Street Community Health Center and Morrow Family Health Center promotes a policy of Zero Tolerance for all forms of workplace violence. This policy covers employees, employers, patients, and all other visitors to the practice. We do not tolerate any form of violence including physical assault, threatening behavior, obscene language, or verbal abuse. This policy is enforced at all times and includes all areas of the property, including the entire building and parking lot.

Workplace violence is serious. Employees responsible for any workplace violence will be terminated. Patients responsible for any workplace violence will be released from our provider's care. All other visitors responsible for any workplace violence will be banned from the Center Street Community Health Center and Morrow Family Health Center properties.

**To provide the best healthcare possible, it is necessary that all patients review and comply with Center Street Community Health Center and Morrow Family Health Center's guidelines for patient rights and responsibilities. Please review the information below.**

**A patient has the right to:**

-Considerate and respectful treatment, regardless of age, sex, race, creed, color, religion, ethnic origin, ancestry, marital status, physical or mental disability, gender preference, veteran status, or criminal record; in an environment free from harm.
-Exercise their rights without fear of services being denied, reduced, suspended or terminated.
-Quality health care that is adequate and humane, delivered in the least restrictive environment, pursuant to any individualized service plan.
-Pay a fee for service which is based on our sliding fee scale.
-Be presumed legally competent except as determined by a court.
-Present any complaint or grievance on matters pertaining to services received or any perceived or actual violation of rights.
-Know the variety of services that are available and to participate in the planning of treatment.
-Refuse treatment at any time and the patient has the right to be informed of the consequences resulting from refusal of treatment.
-Receive confidential treatment.
-Review and obtain a copy of their clinical record.

**A patient has the responsibility to:**

-Give full information to the best of their knowledge about their condition; including symptoms, medications, previous health conditions, any self-referrals, and other care obtained from providers outside the practice.
-Meet with the patient liaison to complete a formal orientation process prior to being seen in the center.
-Keep scheduled appointments or cancel 24 hours prior to the appointment.
Habitual failure to keep scheduled appointments may result in counseling from the patient liaison or dismissal from the practice.
-Ask questions if they do not clearly understand information or instructions about their treatment.
-Follow the treatment plan coordinated by their provider.
-Accept the consequences for their own actions.
-Ensure that payment for care is made promptly and in full.
-Provide the Center with current and accurate insurance and financial documentation.
-Provide the Center with current and accurate contact information.
-Follow all rules and regulations of the Center and to be considerate of and respectful to all staff, caregivers, other patients, and visitors to the Health Center.
-Refrain from using alcoholic beverages or recreational drugs at the Health Center.
-Keep all firearms and other weapons off the Health Center property.

# Center Street Community Health Center Corporate Office - Notice of Privacy Practices

**As required by the Privacy Regulations, created as a result of the Health Insurance Portability Act of 1996 (HIPPA)**

This notice describes how medical information about you (as a patient of this practice) may be used and disclosed, and how you can get access to this information. Please review this notice carefully.

**A. OUR COMMITMENT TO YOUR PRIVACY**

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide. We are required by law to maintain the confidentiality of your PHI. We are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We know these laws are complicated, but we must provide you the following information:

- How we use and disclose your PHI
- Your privacy rights in regard to your PHI
- Our obligations concerning the use and disclosure of your PHI
- How to lodge a complaint about how we handled your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records our practice has created or maintained in the past, and for any of your records we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all times, and you may request a copy of our most current Notice at any time.

**B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT: Center Street Community Health Center, Privacy Officer at 740-751-6380**

**C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:**

1. **TREATMENT**. We may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI to write a prescription, or we might disclose your PHI to a pharmacy when ordering a prescription. Many people who work for our practice - including, but not limited to our doctors and nurses – may use or disclose your PHI to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your friends or family members involved in your care.
2. **PAYMENT.** We may use and disclose your PHI in order to bill and collect payment for services and items you receive. For example, we may contact your health insurer to certify that you are eligible for benefits (and range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover or pay for a treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as friends or family. Also, we may use your PHI to bill you directly for services and items.
3. **HEALTH CARE OPERATIONS.** We may use and disclose your PHI to operate our business. For example, we may use and disclose your PHI for our operations, to evaluate quality of care, to conduct cost-management and business planning activities for our practice, or to train new healthcare workers.
4. **TREATMENT OPTIONS.** We may use and disclose your PHI to inform you of potential treatment options or alternatives.
5. **RELEASE OF INFORMATION TO FRIENDS/FAMILY.** We may release your PHI to a friend or family member involved in your care. For example, a guardian may ask a neighbor take their charge to our office for treatment. This neighbor may have access to the medical information. We may also release information to friend s or family involved in payment of provided health services.
6. **DISCLOSURES REQUIRED BY LAW.** We will use and disclose your PHI when we are required to do so by federal, state, or local law.
7. **BEHAVIORAL HEALTH.** Behavioral health/psychotherapy notes will only be used and disclosed with proper authorization.

**D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES WITHOUT YOUR APPROVAL.**

The following categories describe scenarios in which we may use or disclose your PHI without your consent or authorization.

1. **PUBLIC HEALTH RISKS.** We may disclose your PHI to public health authorities that are authorized by law to collect information for:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition.
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence), however, we will only disclose this if the patient agrees or we are required or authorized to by law.
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. **HEALTH OVERSIGHT ACTIVITIES.** We may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include investigations, inspections, audits, surveys, licensure and disciplinary actions, civil administrative, and criminal procedures or actions, or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general. We may use your PHI to report diseases to the health department.
3. **LAWSUITS AND SIMILAR PROCEEDINGS.** We may disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, or to obtain an order protecting the information the party has requested.
4. **LAW ENFORCEMENT.** We may release your PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct

- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including location of victim(s) of the crime, or description, identity or location of perpetrator)

5. **SERIOUS THREATS TO HEALTH OR SAFETY.** We may use and disclose your PHI to reduce or prevent a serious threat to your health and safety or another individual or the public. Under these circumstances, we will make disclosures to a person or organization able to help prevent the threat.
6. **NATIONAL SECURITY**. We may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We may disclose to federal officials to protect the President, officials or foreign heads of state, or to conduct investigations.

**E. YOUR RIGHTS REGARDING YOUR PHI – YOU HAVE THE FOLLOWING RIGHTS REGARDING THE PHI THAT WE MAINTAIN:**

1. **CONFIDENTIAL COMMUNICATIONS.** You have the right to request our practice communicate with you about your health and related issues in a particular manner or a certain location. For example, you can request that contact be made at home and not at work, or mailed communications must be in sealed envelopes and not a postcard. You may be asked to pay for additional costs incurred to comply with your request. A communication request must be made by written request to our Privacy Officer, specifying the requested method of contact or the location you wish to be contacted. We will accommodate reasonable requests, of which, you do not need to provide reason for your request.
2. **REQUESTING RESTRICTIONS.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to certain individuals involved in your care or payment for your care, such as friends or family. You can request to restrict certain PHI to health plans, if paid in full, out of pocket. You may request no interns or trainees be involved in your care. We are not required to agree; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or if the information is necessary for treatment.
   **To request a restriction, it must be a written request to our Privacy Officer in a clear and concise fashion and must contain:**
   **- Information you wish restricted, whether you wish to restrict use or disclosure or both, to whom you want limit to apply.**
3. **INSPECTION AND COPIES.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical and billing records, but not including psychotherapy notes. You must submit a written request to our Privacy Officer. You may incur a fee for the costs of copying associated with your request.
4. **AMENDMENT.** You have the right to request your PHI if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. The request must be submitted to our Privacy Officer, in writing, including the reason that supports the amendment. If the request is not received this way, our practice will deny the request. We may deny the request if we believe the information is: (a) accurate and complete; (b) not PHI that is kept by our office; (c) not PHI that you are permitted to inspect and copy; or (d) not created by our office, unless the entity that created it is unavailable to amend the information.
5. **ACCOUNTING of DISCLOSURES.** You have the right to request "accounting of disclosures", a list of certain disclosures that we have made of your PHI. We are not required to list use of your PHI as part of the routine patient care, payment, or health operations for paper records. Examples of this include: a provider sharing information with a nurse, the billing department using your PHI to file insurance claims, discussion to improve our health care delivery system. The request must be submitted to our Privacy Officer, in writing. The request may not be longer than six years with paper charts or three years for listings to include treatment and payment from electronic records, from the date of request, and may not include dates before July 15, 2010. The first list request within a 12-month period is at no cost, but we may charge you for additional requests in the same 12-month period. We will notify you of the cost and you may withdraw your request before you incur any costs.
6. **RIGHT TO PAPER COPY OF THIS NOTICE.** You have the right to receive a paper copy of this notice of privacy practices. You will receive a copy at your first visit, but copies are available any time by contacting our Privacy Officer.
7. **RIGHT TO FILE A COMPLAINT.** You have the right to file a complaint with our practice or with the Secretary of the Department of Health and Human Services (contact information is listed below). All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. **RIGHT to PROVIDE an AUTHORIZATION for OTHER USES and DISCLOSURES.** We will obtain your written authorization for uses and disclosures that are not covered by this notice or permitted by applicable law, such as research or marketing. Any authorization you provide for use and disclosure of your PHI can be revoked at any time in writing. Once authorization has been revoked, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your medical care.
9. **RIGHT TO NOTIFICATION.** You have the right to receive notification whenever a breach of your unsecured PHI occurs.

**Please submit all written requests or complaints to:**

Center Street Community Health Center
Privacy Officer
136 West Center Street
Marion, Ohio 43302
Phone: (740)751-6380
Fax: (740)751-4866
www.centerstreetclinic.org

OR, complaints to :

Secretary of the Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, Southwest
Washington, D.C., 20201
Phone: (202)619-0257
Toll Free: (877)696-6775

## General Patient Information  Privacy Practices, and Rights and Responsibility

Name: (Last)_____ (First)_____ (MI) _____ Date of Birth: _____

Printed Name of Parent or Legal Guardian (If applicable): _____

## Notice of Privacy Practices Acknowledgement

I understand that under the **Health Insurance Portability & Accountability Act of 1996 (HIPAA)**, I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.

*Obtain payment from third-party payers.

*Conduct normal healthcare operations such as quality assessments and physicians certifications.

I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this organization at any time to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I received a copy of your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my PHI. I have read the document and understand the information.

## Notice of Rights and Responsibilities Acknowledgement

I understand that this organization has the right to change its NOTICE OF RIGHTS AND RESPONSIBILITIES from time to time and that I may contact this organization at any time to obtain a current copy of the NOTICE OF RIGHTS AND RESPONSIBILITIES. I received a copy your NOTICE OF RIGHTS AND RESPONSIBILITIES containing a more complete description of the guidelines of rights and responsibilities I have while a patient. I have read the document and understand the information.

**Signature: _____ Date: _____**

**Witness Signature: _____ Date: _____**

**If you do not agree with these terms, we will be unable to serve as your provider.**

# General Patient Self-Declaration of Income

**Name: (Last)**_____ **(First)**_____ **(MI)** _____ **Date of Birth**:_____

**Printed Name of Parent or Legal Guardian (If applicable):** _____

## Are you receiving all possible assistance and/or discounts while in our care? Complete this form to find out.

## Household Size: _____

**(**Number of people you are financially responsible for in your home or number of people you claim on your taxes.)

Please list **ALL** income sources for you and those you are financially responsible for.

### 1. Does anyone receive hourly wages from employment? YES NO

If Yes, please complete the following:

**Name:**_____ Pay rate per hour: _____ Hours Worked Weekly: _____

**Name:**_____ Pay rate per hour: _____ Hours Worked Weekly: _____

### 2. Does anyone receive any form of Social Security (SSI, Disability, Retirement)? YES NO

If Yes, please complete the following:

**Name:**_____ Type of Income: _____ Gross Monthly Amount: _____

**Name:**_____ Type of Income: _____ Gross Monthly Amount: _____

### 3. Does anyone receive a pension or funds from investments? YES NO

If Yes, please complete the following:

**Name:**_____ Type of Income: _____ Gross Monthly Amount: _____

**Name:**_____ Type of Income: _____ Gross Monthly Amount: _____

### 4. Does anyone receive any other form of income? (Child Support, Unemployment) YES NO

If Yes, please complete the following:

**Name:**_____ Type of Income: _____ Gross Monthly Amount: _____

**Name:**_____ Type of Income: _____ Gross Monthly Amount: _____

**If we find you eligible for any discount or assistance program we offer, verification of all income must be on file before any benefit could begin.**

# General Patient Community Survey

## How did you hear about us?

**Please circle one of the following:**

Facebook Billboard Website Radio

Newspaper Flyer Pamphlet Friend/Relative

Event Other: (Please Specify) _____

## How did you arrive at your appointment today?

**Please circle one of the following:**

Drove own vehicle Friend/Relative Bus/cab Walk

Other: _____

## Personal Information (Optional)

Name: _____

Address: _____ City: _____ Zip: _____

Email: _____ Phone: _____

Thank you for taking time to complete our survey. Your input is greatly appreciated.