New Patient?
Yes ___ No___

Lee County Cooperative Clinic

An FQHC and FTCA Deemed Facility
PO Box 669- 530 W. Atkins Blvd
Marianna, AR 72360
870-295-5225

Last Name ____________________ First Name ____________________ Middle Name ______________

Maiden Name ____________________ Other Name ____

Physical Address __________________________ City __________________ State _____ Zip __________

Mailing Address __________________________ City__________________ State _____ Zip__________

Social Security Number ________________ Date of Birth _______________ Sex ________ Race __________

Email Address ____________________________________ Are you transgender? Yes _______ No _______

Marital Status: Single _____ Married _____ Divorced _____ Partner _____ Widowed _____ Legally Separated _____

Ethnicity: Hispanic _____ Non-Hispanic _____ Preferred Language: English _____ Spanish _____ Other __________

Homeless: Yes ____ No ___Veteran: Yes ____ No ____ Seasonal Worker: Yes ___ No ___ Migrant Worker: Yes___No___

Public Housing: Yes ___ No ___ Home Phone: ____________________ Cell Phone: ____________________

Insurance Information

	Primary Insurance Holder	Relationship	Policy Number
Medicare			
Medicaid/ARKids			
Insurance/ BCBS/ Other			
Dental Insurance			

Yearly Household Income: (everyone listed below) ____________________ Total number in Household: _______

Please list all members in your household. (husband/wife, mother, father, children, sister, brother, etc.)

Name	Relation to You	Date of Birth	Type of Income	Monthly Income

Proof of income is required for most services and you may be denied services after medical assessment and failure to provide income after the first visit. LCCC reserves the right to refuse or discontinue services to patients as deemed necessary.

Emergency Contact	Relationship	Phone Number

I, the undersigned, hereby authorize the staff members of LCCC to render whatever medical, dental, surgical, laboratory testing, radiological and treatment deemed necessary. If minor, guarantor must sign. I also authorize LCCC to send claims to the insurance carrier and receive payments directly. I also approve the release of information to the insurance company if requested. I accept that I am responsible for services rendered.

Signature ______________________________ Date ______________________

Guarantor Signature ______________________ Date ______________________

Witness ________________________________ Date ______________________

Lee County Cooperative Clinic

About our Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law.

- Our obligations under the law with respect to your personal health information
- How we may use and disclose the health information that we keep about you
- Your rights relating to your personal health information
- How to file a complaint if you believe your rights have been violated
- The conditions that apply to uses and disclosures not described in this notice
- The person to contact for further information about our privacy practices

We are required by law to give you a copy of these notices and obtain your written Acknowledgement that you received a copy of this notice.

Notice of Privacy Practices: Yes or No

Patient Acknowledgement of receipt

I, ____, hereby acknowledge that I received a copy of the Privacy Practices.

Patient Signature ____ Date __________________

Patient's Representative if applicable _____________________________ Date __________________

Witness Signature ____ Date __________________

Notice of Acknowledgement of Advance Directive

Patient Name ______________________________________ Date of Birth ____________________

An Advance Directive is a legal document allowing a person to give direction about future medical care or to designate another person(s) to make medical decisions if he or she should lose decision making capacity. Advance Directive are the following written instruments: The Living Will and The Durable Power of Attorney for Health Care. The instrument may be revoked and notation of the date and time must be made to the patients' medical record.

Do you have an Advance Directive:

A. Directive to Physicians (living will) Yes _____ No_____

B. Durable Power of Attorney for Health Care Yes _____ No _____

Is it up to date? Yes _____ No_____

Where is a copy located? ______________________________________

Principal: ______________________________________

Address: ______________________________________

Phone Number: ______________________________________

Alternate Agent: ______________________________________

Address: ______________________________________

Phone: ______________________________________

Signature of Patient / Representative ______________________________________

te ______________________________________

Lee County Cooperative Clinic

HOW TO CONTACT YOU CONCERNING YOUR HEALTH INFORMATION

We respect your privacy and abide by all laws pertaining to your health information. Please let us know how you wish for us to contact you concerning your health information.

Contact me in writing by United States Mail.	Yes or No
Contact me in writing by electronic mail or patient portals*	Yes or No
Leave a message for me on answering machine and ask me to call not leaving any details of the purpose of the call.	Yes or No
If I cannot be reached, leave a message with the person I have listed as my emergency contact.	Yes or No
Leave a message with a family member for me to call without detail of the call.	Yes or No

Please list any other means that you wish to be used in contacting you.

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*Patient Portals are those secure systems used by us to allow patients to access their medical records, make appointments and review.

*Remember... NO lab results will be given over the phone!

Signature ____ Date ______________________

Revised 12/19/2018

LEE COUNTY COOPERATIVE CLINIC
NOTICE OF PRIVACY PRACTICES

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

We are Required by Law to:

- Ensure that health information that identifies you is kept private and in accordance with federal and state laws
- Provide you this notice as to our legal duties and privacy practices with respect to individually indentifiable health information that we collect and maintain about you
- Allow you to obtain a copy of your health information in paper and electronic form
- Correct any information in your health information that you prove to be inaccurate
- Train our personnel concerning privacy and confidentiality
- Implement a sanction policy to discipline those who breach privacy/confidentiality or our policies with regard to Personal Health Information (PHI)
- Mitigate (lessen the harm)any breach of privacy/confidentiality
- Abide by terms of this notice

Who We May Disclose Health Information to and Reasons for Disclosure

- To a specialist in which our health center is sharing in the treatment
- We may disclose your health information to your insurance provider, Medicare, Medicaid and other health plan providers for billing of services
- Public Health, abuse or neglect and health oversight. Example: To alert a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease
- Workers Compensation relating to a work-related injury that you were treated for at our health center
- Authorization required by law including legal proceedings where a subpoena has been issued
- In the event of a death that may be the result of criminal conduct
- To identify or locate a suspect, fugitive, material witness or missing person
- Information may be released or disclosed to a coroner, medical examiner, or funeral director to assist in the performance of their duties in accordance with applicable law
- To prevent a threat to National Security
- To a business associate who provides services through a contract and who has signed a HIPAA Business Agreement
- If you are an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.
- We may disclose your health information to the Department of Health and Human Services (HHS) as necessary to determine our compliance with those standards.

Disclosure for Which Authorization is Required:

- Use for Psychotherapy
- For marketing purposes including subsidized treatment communication
- Disclosures that constitute a sale of Personal Health Information
- Disclosure to health insurance providers where you paid the full amount of the services
- Disclosure to any third party that is not listed in (Who We May Disclose Your Information to)
- We will notify you in writing of all other disclosures that are not listed here and request your permission for such disclosure.

Note: The list above is not inclusive and there may be other instances in which your Authorization is required for release of your Personal Health Information

Notice of Intent:

- We may contact you by mail or phone calls to remind you of your appointment
- We may contact you to provide information regarding your treatment alternatives or other health-related benefits and services.
- If we decide to contact you concerning fundraising, we will first ask for your approval.

Right to Restrict Disclosure: You have a right to request restrictions or limitations on certain uses and disclosures of your Personal Health Information. Each individual request will be reviewed to determine if the restriction is within your rights. You have a right to request and receive an accounting of all disclosures of your Personal Health Information.

Right to Inspect and Copy: You have a right to inspect and copy your Personal Health Information. You have a right to receive the information electronically once we have such authorization in writing. If you feel that this information is incorrect or incomplete, you may ask us to amend the information.

Instances Where Right to Copy or Inspect May be Refused:

- Psychotherapy notes that are recorded in any medium by a health care provider who is a mental health professional documenting or analyzing a conversation during a private, group, joint, or family counseling session and that are separated from the rest of your medical record.
- Information compiled in reasonable anticipation of or for use in civil, criminal, or administrative actions or proceedings
- Protected Health Information that is subject to the Clinical Laboratory Improvement Amendments 1988 (CLIA), 42 USC §263a, to the extent that giving you access would be prohibited by law.
- Information that was obtained from someone other than a health care provider under a promise of confidentiality and the requested access would be reasonably likely to reveal the source of the information.
- Information that is copyright protected, such as certain rad data obtained from testing

Note: In other situations, we may deny you access, but if we do, we must provide you a review of our decision denying access. These reviewable grounds for denial include the following.

- ❖ A licensed health care professional, such as your attending physician, has determined in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of you or another person.
- ❖ Protected Health Information makes reference to another person (other than a health care provider) and a licensed health care provider has determined in the exercise of professional judgment, that the access is reasonably likely to cause substantial harm to such other person.
- ❖ The request is made by your personal representative and a licensed health care professional has determined, in the exercise of professional judgment that giving access to such personal representative is reasonably likely to cause substantial harm to you or another person.
- ❖ For these reviewable grounds, another licensed professional must review the decision of the provider denying access within 60 days. If we deny you access, we will explain why and what your rights are, including how to seek review. If we grant access, we will tell you what, if anything, you have to do to get access. We reserve the right to charge a reasonable cost-based fee for making copies.

If We Deny Your Request for Amendment/Correction: If we deny your request for amendment/correction, we will notify you why, how you can attach a statement of disagreement to your records (which we may rebut) and how you can complain. If we grant the request, we will make the correction and distribute the correction to those who need it and those whom you identify to us that you want to receive the corrected information.

Changes to this Notice: We reserve the right to make changes to this notice. If changes are made, we will make the changes readily available to you upon request on or after the effective date of the revisions to existing patients who request a copy and we will post the revised copy in our centers. Copies may also be found on our website, www.leecountycooperativeclinic.com.

Breaches: If your Protected Health Information is breached, we will notify within sixty (60) days of the breach that your Protected Health Information has been breached. We will take every precaution and steps as required by federal and state law to circumvent any damages caused by the breach.

Complaints: If you believe that there has been a violation of your Privacy Rights, you may file a complaint with the Secretary of the Department of Health and Human Services.

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201
You may email to OCRComplaint@HHS.gov. Complaints may be filed with our Privacy Officer by mail, email or fax:

Privacy Officer: Kimberly Brown
kbrown@lccc.us.com
530 Atkins Boulevard
Marianna, AR 72360
870-298-4258
Fax: 870-295-4073

Approved:

Kellee Farris, PhD

CEO

01/10/19

Date

LEE COUNTY COOPERATIVE CLINIC

Verification of Income Statement

I, ______________________________, do hereby state and affirm that my weekly/monthly/yearly income is __________________. I further understand that this income places me at the 100% or below poverty guidelines to receive services from Lee County Cooperative Clinic at the least discounted rate based on a Sliding Fee Scale. I understand that I am to notify Lee County Cooperative Clinic of any changes in my income, and the changes may result in my paying a higher sliding fee for services. Fraudulent statements may result in my paying the actual cost of services.

____

Patient

____

Witness

____

Date