New Patient Welcome Packet

(Please fill out and return to Genesis Family Health completed)

Medical Clinics & Care Centers

712 St. John St. Side A	1700 Ave F	121 W. 3rd St.	202 W. Kansas Ave	310 E. Grant Ave
Garden City, KS 67846	Dodge City, KS 67801	Liberal, KS 67901	Ulysses, Kansas 67880	Ulysses, Kansas 67880
(620)275-1766	(620)225-6821	(620)624-0463	(620)356-5870	(620)356-4050
Mon-Fri 8am-5pm	Mon-Thur 8am-7pm	Mon-Thur 8am-7pm	Mon-Fri 8am-5pm	Mon-Fri 8am-5pm
Closed for lunch 1pm-2pm	Closed for lunch 1pm-2pm	Closed for lunch 1pm-2pm	Closed for lunch 1pm-2pm	Closed for lunch 1pm-2pm

Dental Clinics

310 E. Walnut St Ste. LL5	2011 Central Ave
Garden City, KS 67846	Dodge City, KS 67801
(620)272-0570	(620)227-9797
Mon-Thur 7am-6pm	Mon-Thur 7am-6pm
Closed for lunch 1pm-2pm	Closed for lunch 1pm-2pm

Last modified 6/1/2017

WELCOME TO GENESIS FAMILY HEALTH!

We are so pleased that you have chosen us to be your partners in healthcare. Genesis Family Health (GFH) is a Federally Qualified Health Center (FQHC), which means three very important things: the first is that everyone is welcomed through our doors. There are no exclusions of any type. The second is that GFH is your community Health Center. All FQHCs are ran by their patient members. The third is we offer a Sliding Fee Discount to patients based on annual income and the number of people residing in the household. So, if you feel we are not meeting your needs, please let us know. Also, if you would like to serve on our Board of Directors, please let us know.

When you chose to become a Genesis Family Health patient, you are automatically registered for every service we offer. These services include not only comprehensive medical, dental, behavioral health, and nutrition services, but also help with other challenges you may be facing such as transportation, housing, insurance enrollment, and accessing affordable medications. We have six conveniently located sites in Garden City, Dodge City, Liberal and Ulysses.

If you have any questions concerns, or suggestions at any time, please do not hesitate to contact one of our staff. Once again, thank you so much for choosing us as your healthcare provider.

Sincerely,

Julie Wright
CEO

GENESIS FAMILY HEALTH

REGISTRATION FORM

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div. / Sep / Wid.

Employment Status: ❑Full time ❑Part Time ❑ Retired ❑Unemployed	Preferred Name:	Birth date: / /	Age:	Sex: M F	Sex at Birth: ❑ M ❑ F

Mailing Address:	City:	State & Zip Code:

Social Security no.:	Email Address:	Home phone no.: ( )	Cell phone no.: ( )

Employer:	Work phone no.: ( )	Pharmacy:

How would you like us to contact you: ❑ Mail ❑ Phone ❑ Text Message ❑ Patient Portal

Race: ❑ White ❑ Black or African American ❑ Asian ❑ Native Hawaiian ❑ Other Pacific Islander ❑ More than one race ❑ Declined
Are you Hispanic/Latino: ❑ Yes ❑ No **Preferred Language**: ❑ English ❑ Spanish ❑ Other ________________

Homeless: ❑ Yes ❑ No **Public Housing:** ❑ Yes ❑ No **Veteran:** ❑ Yes ❑ No
Have you or has anyone in your household worked in agriculture, such as planting, cultivating, or harvesting (fruits, vegetables, grains, or dairy) in the last 2 years as a: ❑ Seasonal worker ❑ Migrant worker

Sexual Orientation: ❑ Straight (not lesbian or gay) ❑Lesbian or Gay ❑Bisexual ❑Transgender ❑Choose not to disclose ❑Other _______

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Mailing Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Cell phone no.: ( )

Please indicate primary insurance ❑ Medicaid ❑ Medicare ❑ Commercial ❑ Workers Comp ❑ No Insurance ❑ Other _______________

Name of Policy Holder:	Policy Holder's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Name of Policy Holder:	Group no.:	Policy no.:

Patient's relationship to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY / PERMISSION TO SHARE

Name of local friend or relative (in case of an emergency):	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

Name of local friend or relative (permission to share information):	Type of information that can be shared: ❑ Medical ❑ Behavioral ❑ Dental ❑ Billing ❑ ALL RECORDS

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Genesis Family Health or insurance company to release any information required to process my claims. I also consent for my or child's photo to be taken for record purposes. I hereby acknowledge that I have received a copy of GFH's Notice of Patient Rights, Notice of Privacy Practices.

Patient/Guardian signature *Date*

CONSENT FOR ADULT OR MINOR INTEGRATED HEALTH EVALUATION AND/OR TREATMENT FORM

1. **Consent to Evaluate / Treat:** I voluntarily consent that I and / or my child will participate in medical, social services, dental and/or mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from Genesis Family Health. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:

   a. The benefits of the proposed treatment
   b. Alternative treatment modes and services
   c. The manner in which treatment will be administered
   d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
   e. Probable consequences of not receiving treatment

   The evaluation or treatment will be conducted by a dentist, hygienist, physician assistant, physician, psychotherapist, a psychologist, psychiatric nurse practitioner, psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Kansas Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Counseling, and the Board of Healing Arts.

   Benefits to Evaluation / Treatment: Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to myself and/or my child, as well as the referring professional, to understand the nature and cause of any difficulties affecting myself and/or my child's daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this Evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

2. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

3. **Confidentiality, Harm, and Inquiry:** Information from my child's evaluation and/or treatment is contained in a confidential medical' record at Genesis Family Health, and I consent to disclosure for use by Genesis Family Health staff for the purpose of continuity of mine or my child's care. Information provided will be kept confidential with the following exceptions: 1) if I and/or my child is deemed to present a danger to himself/herself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

4. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment of myself and/or my child at any time by providing a written request to the treating clinician.

5. **Expiration of Consent**: This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of myself and/or child. I also attest that I am the legal guardian and have the right to consent for the treatment of minor child. I understand that I have the right to ask questions of mine and/or minor's service provider about the above information at any time.

______________________________ ______________________

Patient/Guardian signature *Date*

Last modified 6/1/2017

DISCOUNTED/SLIDING FEE APPLICATION FORM

It is the policy of Genesis Family Health to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family income and size. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services which are purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such services. In the hope that your financial situation improves, discounts apply only to current, not future services. Please inquire at the front desk if you have questions.

Name	Birthdate	Relationship to you
1	/ /	SELF
2	/ /	
3	/ /	
4	/ /	
5	/ /	
6	/ /	
7	/ /	
8	/ /	

Include income from all sources including gross wages, tips, social security, disability, pensions, annuities, veterans' payments, net business or self-employment, alimony, child support, military, unemployment, and public aid.

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved. **For dependent(s) verification, copies of birth certificates, immunization records, or school ids may be required.**

______________________________ __________________
Patient/Guardian signature *Date*

*****PLEASE PROVIDE PROOF OF INCOME*****

Office Use Only

Patient Name______________________________ Slide: ________________________

Date of Service _____________________________ Approved by ____________________

☐ **I am declining my right to apply for financial assistance. By signing this, I have refused to provide proof of income.**

______________________________ __________________
Patient/Guardian signature *Date*

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. PLEASE REVIEW IT CAREFULLY. You have the right to a paper copy of this Notice: you may request a copy at any time.

Effective Date of This Notice: January 1, 2017

If you have questions about any part of this notice or if you want more information about our privacy practices please contact:
Privacy and Compliance
Genesis Family Health Administration Office
122 W. Laurel Garden City, KS 67846
(620) 271-7400

All written requests outlined in this Notice should be addressed to the above named individual

Genesis Family Health is required by law to maintain the privacy of protected health information, to provide individuals with notice of its legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information.

HOW GENESIS FAMILY HEALTH MAY USE AND DISCLOSE HEALTH INFORMTION ABOUT YOU

Genesis Family Health may use and disclose your health information for the following purposes without your express consent or authorization.

Treatment: We may use your health information to provide you with medical treatment. We may disclose information to doctors, nurses, technicians, medical students, or other personnel involved in you care. We also may disclose information to other persons or organizations involved in your treatment, such as other health care providers, family members and friends.

We may use and disclose health information to discuss with you treatment options or health-related benefits or services or to provide you with promotional gifts of nominal value. We may use and disclose your health information to remind you of upcoming appointments. Unless you direct us otherwise, we may leave messages on your telephone answering machine identifying Genesis Family Health and asking for you to return our call. We will not disclose any health information to any person other than you except to leave a message for you to return the call.

Payment: We may use and disclose and disclose your health information as necessary to collect payment for services we provide to you. We also may provide information to other health care providers to assist them in obtaining payment for services they provide to you.

Health Care Operations: We may use and disclose your health information for our internal operations. These uses and disclosures are necessary for our day-to-day operations and to make sure patients receive quality care. We may disclose health information about you to another health care provider or health plan with which you also have had a relationship for purposes of that provider's or plan's internal operations.

Business Associates: Genesis Family Health provides some services through contracts or arrangements with business associates to appropriately safeguard your information.

Creation of De-Identified Health Information: We may use your health information to create de-identified health information. This means that all data items that would help identify you are removed or modified.

Uses and Disclosures Required by Law: we will use and/or disclose your information when required by law to do so.

Disclosures for Public Health Activities: We may disclose your health information to a government agency authorized (a) to collect data for the purpose of preventing or control disease, injury or disability; or (b) to receive reports of child abuse or neglect. We also may disclose such information to a person who may have been exposed to a communicable disease if permitted by law/

Disclosures about Victims of Abuse, Neglect, or Domestic Violence: We may disclose your health information to a government authority if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

Disclosures for Judicial and Administrative Proceedings: We may disclose your health information to a law enforcement official as required by law or in compliance with court order, court-ordered warrant, a subpoena, or summons issued by a judicial officer; a grand jury subpoena: or an administrative request related to a legitimate law enforcement inquiry.

Disclosures for Law Enforcement Purposes: We may disclose your health information to a law enforcement official as required by law or in compliance with a court order, court-ordered warrant, a subpoena, or summons issued by a judicial officer; a grand jury subpoena; or an administrative request related to a legitimate law enforcement inquiry.

Disclosures Regarding Victims of a Crime: In response to a law enforcement official's request, we may disclose information about you with your approval. We may also disclose information in an emergency situation or if you are incapacitated if it appears you were the victim of a crime.

Disclosures to Avert a Serious Threat to Health or Safety: We may disclose information to prevent or lessen a serious threat to the health and safety of a person or the public or as necessary for law enforcement authorities to identify or apprehend an individual.

Disclosures for Specialized Government Functions: We may disclose your protected health information as required to comply with governmental requirements for national security reasons or for protection of certain government personnel or foreign dignitaries.

Disclosures for Fundraising: We may disclose demographic information and dates of service to an affiliated foundation or business associated that may contact you to raise funds for Genesis Family Health. You have a right to opt out of receiving such fundraising communications.

OTHER USES AND DISCLOSURES

We will obtain your express written authorization before using or disclosing your information for any other purpose not described in this Notice. For example, authorizations are required for use and disclosure of psychotherapy notes, certain types of marketing arrangements, and certain instances involving the sale of your information. You may revoke such authorization, in writing, at any time to the extent Genesis Family Health has not relied on it.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy: You have the right to inspect and copy health information maintained by Genesis Family Health. To do so, you must complete a specific form providing information needed to process your request. If you request copies, we may charge a reasonable fee. We may deny you access in certain limited circumstances. If we deny access you may request review of that decision by a third party and we will comply with the outcome of the review.

Right to Request Amendment: If you believe your records contain inaccurate or incomplete information, you may ask us to amend the information. To request an amendment, you must complete a specific form providing information we need to process you request, including the reason that supports you request.

Right to an Accounting of Disclosures and Access Report: You have the right to request a list of disclosures of your health information we have made, with certain exceptions defined by law. To request an accounting or an access report, you must complete a specific written form providing information we need to process your request.

Right to Request Restrictions: You have the right to request a restriction on our uses and disclosures of your health information for treatment, payment or health care operations. You must complete a specific written form providing information we need to process your request. Genesis Family Health 's Privacy/Compliance Officer is the only person who has the authority to approve such a request Genesis Family Health is not required to honor your request for restrictions, except if (a) the disclosure is for purposes o carrying out payment or health care operations and is not otherwise required by law, and (2) the protected health information pertains solely to a health care item or services for which you or any person (other than a health plan on your behalf) has paid Genesis Family Health in full.

Right to Request Alternative Methods of Communication: You have to right to request that we communicate with you in a certain way or at a certain location. You must complete a specific form providing information needed to process your request. Genesis Family Health's privacy officer is the only person who has the authority to act on such a request. We will not ask you the reason for our request, and we will accommodate all reasonable requests.

Rights Relating to Electronic Health Information*:* Genesis Family Health participates in electronic health information exchange, or HIE. New technology allows a provider or a health plan to make a single request through a health information organization, or HIO, to obtain electronic records for specific patient from other HIE participants for purposes of treatment, payment or health care operations.

You have two options with respect to HIE. First, you can permit authorized individuals to access your electronic health information through an HIO. If you choose this option, you do not have to do anything. Second, you can restrict access to all of your electronic health information (except access by properly authorized individuals as needed to report specific information as required by law). If you wish to restrict access, you must complete and submit a specific form available at http://www.khie.org. You cannot restrict access to certain information only: your choice is to permit or restrict access to all of your information.

If you have questions regarding HIE or HIOs, please visit http//www.khie.org for additional information. Your decision to restrict access through an HIO does not impact other disclosures of your health information. Providers and health plans may share your information directly through other means (*e.g.,* facsimile or secure e-mail) without your specific written authorization

If you receive health care services in a state other than Kansas, different rules may apply regarding restrictions on access to your electronic health information. Please communicate directly with your out-of-state health care provider about what action, if any you need to take to restrict access.

COMPLAINTS

If you believe your rights with respect to health information have been violated, you may file a complaint with Genesis Family Health or with the Secretary of the department of Health and Human Services. To File a complaint with Genesis Family Health, Please contact Privacy/Compliance Officer, Genesis Family Health Administration , at 122 W. Laurel, Garden City, KS 67846. All your complaints must be submitted in writing. **You will not be penalized for filing a complaint. You may not be required to waive the right to file a complaint with Secretary of Health and Human Services (HHS) as a condition of receiving treatment form this office.**

Genesis Family Health reserves the right to change the terms of this Notice and to make the revised Notice effective with respect to all protected health information regardless of when the information was created.

GENESIS FAMILY HEALTH
PATIENT RIGHTS & RESPONSIBILITIES

As a Genesis Family Health patient/client, you can...

- Expect to be treated with respect and consideration.
- Expect to have calls returned and questions answered in a timely manner.
- Expect to be free from abuse.
- Expect to be free from discrimination based on your race, color, creed, religious belief, sex, age, political belief, disability, health, sexual orientation, the amount of money you have, or the country you were born in.
- Expect freedom to express your religious and/or spiritual beliefs.
- Expect to have the services that are provided explained to you.
- Expect to have a choice to agree to services or to choose a different provider if one is available within the agency.
- Expect to be told about other resources in the community that may be helpful to you and/or your family.
- Expect that information about you will not be shared without your permission within the limits of Kansas law (e.g., mandated reporting, harm to self or others, subpoena).
- Expect to see your file/chart if you want once you have followed written guidelines.
- Expect to have information presented to you in a way that you can understand, including information provided in your own language.
- Bring any comments or suggestions about the quality of your services to the attention of a staff person of the agency, and be aware of the agency grievance policy if you have concerns.
- Have the right to contact the Practice Manager at any time that you feel your rights are not being respected or if you have any concerns or problems you feel are not being addressed.
- Expect to receive services in a safe environment.

As your healthcare partner/provider, Genesis Family Health expects you to...

- Be actively involved in your services and service planning process.
- Provide us with all relevant information as a basis for receiving services and participating in service decisions.
- Let us know if you move and/or get a new phone number.
- Keep scheduled appointments or cancel if you cannot keep an appointment.
- Follow the rules in the Consent for Integrated Health Evaluation and/or Treatment form.
- Act responsibly and be respectful of our staff, property and other patients.
- Accept your financial responsibility to our agency and pay your bills as agreed.

FREQUENTLY MISSED APPOINTMENTS NOTIFICATION

To all Genesis Family Health Integrated Care Patients:

As of ___**April 10, 2017**_____, GFH will implement a Frequently Missed Appointment Policy to reduce the number of missed appointments by patients who do not contact the clinic to cancel. GFH wants to ensure that patients who accept responsibility for their health care are able to schedule appointments when necessary. Patients who schedule appointments and then do not show for their treatment take needed time from other patients.

GFH will:

Notify you of upcoming appointments through telephone and/or the patient portal. Please ensure GFH front desk staff have a telephone number you use for your contact information.

Notify patients who miss a 1st appointment and 2nd appointment within a 12-month period of their missed appointments.

Notify a patient who misses a 3rd appointment without canceling their appointment that they are placed on a Same Day Appointment Status. This status means the patient is only eligible for same day appointments. These appointments will be made only if there is time in the practitioners' schedule on the day the patient contacts the clinic. The patient will be required to call daily until an opening in the clinic's schedule will allow for their appointment.

How do you prevent Same Day Appointment Status?

If you have a scheduled appointment and cannot make the appointment, contact the clinic at the earliest time possible, preferably 24-hours in advance of your appointment time.

If you miss an appointment due to an extreme, unforeseen situation arising, notify the clinic, reschedule your appointment, and share the situation with the front desk staff to note your file.

If there are reasons why you cannot attend your appointment that we may be able to help with, such as transportation and/or the inability to pay the entire cost of your appointment, it is better you share these issues with the clinic. We may be able to help with these circumstances and continue your health care

Keep your appointments!

Your Health Care is important! Keep your appointments and Stay Healthy!

ACKNOWLEDGEMENT OF FORMS

Patient and Center Rights and Responsibilities

I acknowledge that I have received a copy of Genesis Family Health's Patient and Center Rights and Responsibilities form. We ask you acknowledge your receipt of this document by signing below. You should keep a copy of the Center's Patient and Center Rights and Responsibilities; however, if you wish to receive another copy you may request a copy at any time. The most current copy of Center's Patient and Center Rights and Responsibilities will be posted in our office. I acknowledge that I received a copy of my provider's Center's Patient and Center Rights and Responsibilities ___________________________.

(Initials)

I have disclosed all insurance coverage in effect at the time services were provided to me. I understand that failure to inform Genesis Family Health of any third party insurance coverage will be considered fraud and I understand that the clinic will prosecute to the fullest extent to the law.

Notice of Privacy Practices

Maintaining privacy of your health information is very important to us. You have been asked to review our Notice of Privacy Practices. We ask you acknowledge your receipt of this Notice by signing below. You should keep a copy of the Notice; however, if you wish to receive another copy you may request a copy at any time. The most current copy of this Notice will be posted in our office. I acknowledge that I received a copy of my provider's Notice of Privacy Practices effective ____________________.

(Initials)

Frequently Missed Appointment Notification Letter

I acknowledge that I have received a copy of Genesis Family Health's Frequently Missed Appointment Notification letter. We ask you acknowledge your receipt of this document by signing below. You should keep a Frequently Missed Appointment Notification letter however, if you wish to receive another copy you may request a copy at any time. I acknowledge that I received a copy of Frequently Missed Appointment Notification letter

___________________________.

(Initials)

____________________________________	____________________________________
Print Patient Name	Patient Date of Birth
____________________________________	____________________________________
Patient/Guardian signature	Relationship to Patient
____________________________________	____________________________________
Organization Representative	Date