Keystone Rural Health Consortia, Inc.
One Team Working Together For Better Community Health Care

PATIENT INFORMATION

PATIENT PROFILE

Requested Provider: _____

First Name: _____ Middle: _____ Last Name: _____

DOB: _____ **SSN:** _____

Phone: _____ Home: _____ Cell: _____

Work: _____ Email: _____

Street Address: _____ P.O. Box: _____ City: _____ State: _____ Zip: _____

Sex at Birth: ☐ Male ☐ Female **Preferred Pharmacy:** _____

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male-Female ☐ Transgender Female-Male ☐ Other ☐ Choose Not to Disclose ☐ Unknown

Sexual Orientation: ☐ Lesbian/Gay ☐ Straight ☐ Bisexual ☐ Other ☐ Don't Know ☐ Choose Not to Disclose ☐ Unknown

Residence Status: ☐ Lives in own home/apartment ☐ Temporary (Please Specify): _____ ☐ Homeless ☐ Shelter ☐ Transitional Housing ☐ Double Up ☐ Street

Preferred Language: _____ **Secondary Language:** _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed **Are you a Veteran?** ☐ Yes ☐ No

Emergency Contact(s): _____ Phone: _____ Relationship: _____
****** This is not the same as your HIPAA Contacts ********

Patient Employment: ☐ Employed ☐ Retired ☐ Unemployed ☐ Student ☐ Other

Name of Employer: _____ Employer Phone: _____

Approximate Yearly Income (For Grant Reporting Purposes Only):
☐ $0-10,000 ☐ $30,001-50,000 ☐ $70,001-90,000 ☐ $10,001-30,000 ☐ $50,001-70,000 ☐ $90,001-110,000 ☐ $110,000+

Number of People in Household: _____

GUARANTOR INFORMATION

Guarantor (PERSON RESPONSIBLE FOR BILL): ☐ Same as Patient

Name: _____

Address: _____ City/State: _____

DOB: _____ **SSN:** _____

Employer: _____ Employer Phone: _____

Primary Insurance (Patient's Insurance Card Information):

☐ Same as Patient ☐ Same as Guarantor ☐ Other **Relationship to Insured/Guarantor:** _____

Insured Party: _____ Insured Phone: _____ SSN: _____

Insurance Company: _____ Insured ID: _____ Policy/Group #: _____

Address: _____ City/State: _____ Date of birth: _____

Secondary Insurance

☐ Same as Patient ☐ Same as Guarantor ☐ Other ☐ Copay Amount _____

Relationship to Insured/Guarantor: _____

Insured Party: _____ Insured Phone: _____ SSN: _____

Insurance Company: _____ Insured ID: _____ Policy/Group #: _____

Address: _____ City/State: _____ Date of birth: _____

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DEMOGRAPHIC CHART

UDS Support Center, 866-UDS-HELP, udshelp330@bphcdata.net, BPHC Contact Form

Table 3B: Demographic Characteristics
Calendar Year: January 1, 2023 through December 31, 2023

	Patients by Race and Hispanic, Latino/a, or Spanish Ethnicity									
Line	Patients by Race	Yes, Mexican, Mexican American, Chicano/a (a1)	Yes, Puerto Rican (a2)	Yes, Cuban (a3)	Yes, another Hispanic, Latino/a, or Spanish Origin (a4)	Yes, Hispanic Latino/a, Spanish Origin, Combined (a5)	Total Hispanic, Latino/a, or Spanish Origin (a) (Sum Columns a1 + a2 + a3 + a4 +a5)	Not Hispanic Latino/a, or Spanish Origin (b)	Unreported /Chose not to disclose ethnicity (c)	Total (d) (Sum Columns a + b + c)
1a	Asian Indian									
1b	Chinese									
1c	Filipino									
1d	Japanese									
1e	Korean									
1f	Vietnamese									
1g	Other Asian									
1	Total Asian (Sum Lines 1a+1b+ 1c+1d+1e+1f+1g)									
2a	Native Hawaiian									
2b	Other Pacific Islander									
2c	Guamanian or Chamorro									
2d	Samoan									
2	Total Native Hawaiian/ Other Pacific Islander (Sum Lines 2a+2b+ 2c+2d)									
3	Black/African American									
4	American Indian/ Alaska Native									
5	White									
6	More than one race									
7	Unreported/Chose not to disclose race									
8	**Total Patients** (Sum Lines 1+2+3 to 7)									
7	2023 UDS REPORTING TABLES | Instructions for Tables 3A and 3B									

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CONSENT TO TREAT

CONSENT TO TREATMENT

I authorize Keystone Rural Health Consortia, Inc. (KRHC), and its medical, nursing and other professional staff members, to provide such health care services and administer such diagnostic and therapeutic procedures and treatments as, in the judgment of KRHC's medical personnel, is deemed necessary or advisable in my care. This includes all routine diagnostic tests and procedures, including diagnostic x-rays, the administration and/or injection of pharmaceutical products and medications, and the withdrawal of blood for laboratory examination. I understand that no guarantees have been made to measure the results or effectiveness of treatments or examinations performed by KRHC personnel.

SURE SCRIPTS

I authorize Keystone Rural Health Consortia, Inc., and its clinical support staff to query Sure Scripts regarding medication history.

RELEASE OF INFORMATION

I authorize KRHC to use and disclose my health information for the following purposes: (1) to provide for, arrange or coordinate my health care treatment; (2) to enable KRHC to obtain payment for the services it provides to me; and (3) to permit KRHC to carry out ordinary health care and business operations such as quality assurance, service planning and general administration.

I am aware that Keystone Rural Health Consortia, Inc., may share information with my other medical or dental providers for medical or dental treatment or with a third party for financial payment through electronic means.

ASSIGNMENT OF BENEFITS

I assign to KRHC all benefits to which I may be entitled from Medicare, Medicaid, other government agencies, insurance carriers and other third parties who are financially liable for the medical care and treatment provided by KRHC.

FINANCIAL OBLIGATIONS

I agree that, except as may be limited by law or KRHC's agreements with third party payers, in the event of non-payment by a third party for which I have provided an assignment of benefits, I am obligated to pay all amounts due for services provided at KRHC facilities in accordance with the rates and terms of KRHC in effect on the date of service. I also agree that I am responsible for any applicable copayments, coinsurance or deductibles.

I certify that I have read this form and that I am the patient, or I am duly authorized by the patient as the patient's representative to execute this form and accept its terms.

Patient or Responsible Party Signature: _____ Date: _____

Nature of Relationship to Patient: _____ Date: _____
(if patient not signing)

POS Reorder 2316550
Rev. 8/23

Keystone Rural Health Consortia, Inc.
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PATIENT PRIVACY

PATIENT PRIVACY INFORMATION FORM

Patient Name: _____ Date of Birth: _____

To comply with federal regulations regarding your privacy in our office, we ask that you identify who we may speak to in regard to your health information and care.

Please indicate below any other persons we may speak to regarding you and your health information. This information will be used at all our locations listed below and can be updated in writing at any time during the year.

Ridgway Medical Center
Cameron County Health Center
Kane Dental Center
Johnsonburg Dental Center

Fox Township Dental Center
Cameron County Dental Center
Bradford Dental Center

Contact Name: _____ Phone Number: _____

Contact Name: _____ Phone Number: _____

Contact Name: _____ Phone Number: _____

Contact Name: _____ Phone Number: _____

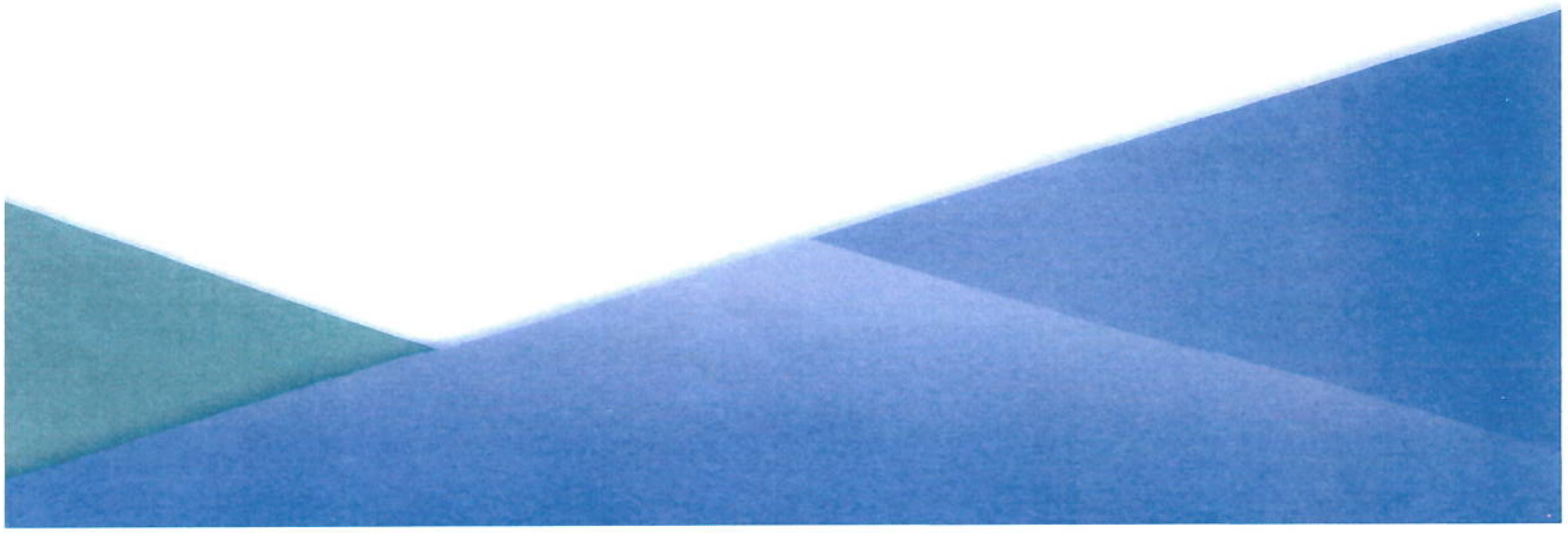
Please also answer the following questions for **YOU AND YOUR** contacts:

- May we leave messages with results on your home/cell phone voicemail: ☐ Yes ☐ No
- May we leave messages on your or your contacts' work voicemail: ☐ Yes ☐ No
- May we send an email: ☐ Yes ☐ No
- May we send through the mail: ☐ Yes ☐ No
- May we send messages through text: ☐ Yes ☐ No

This form will be valid for one year from the signed date below.

_____ _____ _____

Patient/Representative Relationship Date



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PAYMENT COLLECTION

Thank you for choosing KRHC as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans. If you are not insured by a plan we accept, payment in full is expected at each visit. If you are insured by a plan we do accept but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles.** All co-payments must be paid at the time of service. All deductibles will be billed to patient and must be paid within 30 days of receipt of statement. Co-payments and deductibles are part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

3. **Non-covered services.** Please be aware that certain services you receive may be non-covered or not considered reasonable or necessary by your insurance. You must pay for these services in full at the time of the visit. Our staff will make every effort possible to notify you in advance in this circumstance.

4. **Proof of Insurance.** Patients must provide a driver's license and current valid insurance card at each visit before seeing the provider as proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes.

7. **Nonpayment.** If your account is over 150 days past due and you have not responded to a payment plan request, you will receive a collection letter. If payment is not negotiated or received in full within 30 days, our providers will only be able to treat you on an emergency basis.

8. **Missed appointments.** Our policy is to track missed appointments not cancelled within a reasonable amount of time. Three missed appointments without cancellation within a 12 month period will result in termination from our practice. Please help us serve you better by keeping your regularly-scheduled appointment.

KRHC is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understand the payment policy and agree to abide by the guidelines.

_____ _____

Signature of patient or responsible party Date

PATIENT AND CENTER RIGHTS AND RESPONSIBILITIES

Name:_____ Date of Birth:____/____/____ MR#:_____

WELCOME TO THE CENTER.

When it comes to health care, whether you're seeking wellness, recovering from illness or managing a chronic condition, it's a cycle of staying well, getting well and being well. If you deal with these health situations in a long-term relationship with a trusted medical provider, then you've found your Patient-Centered Medical Home here with us.

Our goal is to provide quality health care to people in this community, regardless of their ability to pay. As a patient, you have rights and responsibilities. The center also has rights and responsibilities. We want you to understand these rights and responsibilities so you can help us provide better health care for you. Please read and sign this statement and ask us questions you might have.

A. Human Rights

You have a right to be treated with respect regardless of race, color, marital status, religion, sex, national origin, ancestry, physical or mental handicap or disability, age, Vietnam-era veteran status, or other grounds as applicable to federal, state and local laws or regulations.

B. Payment For Services

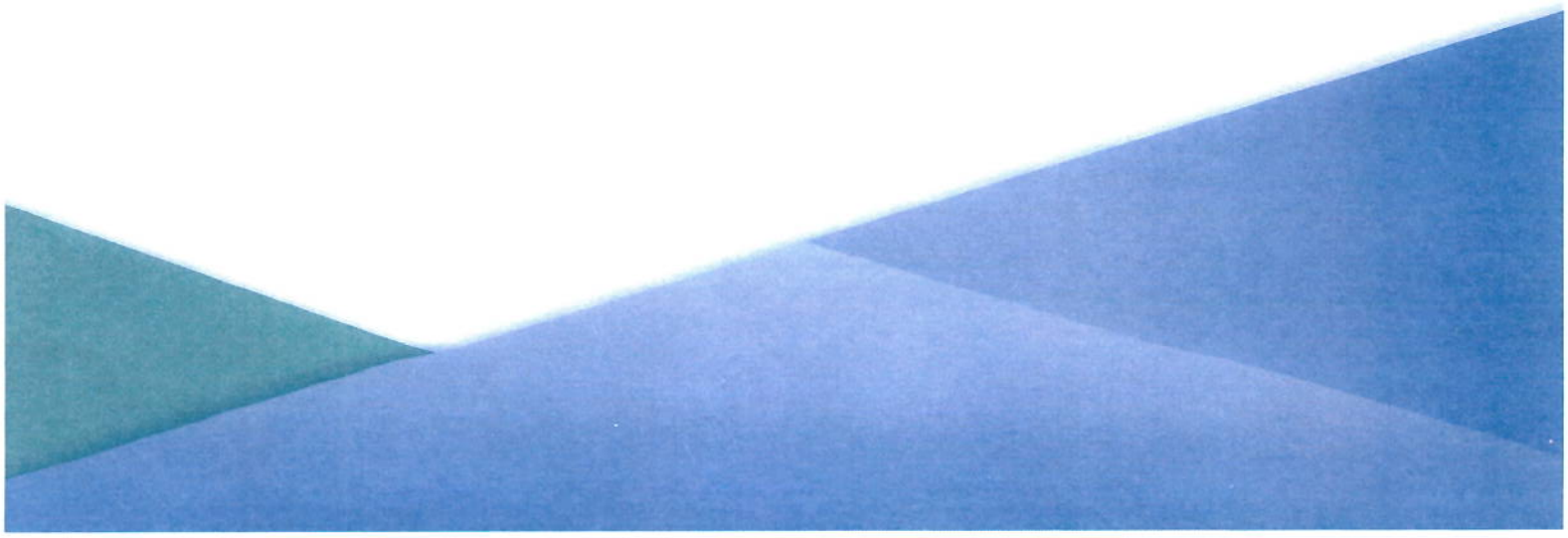
1. You are responsible for giving staff accurate information about your present financial status and any changes in your financial status. The staff needs this information to decide how much to charge you and/or so they can bill private insurance, Medicaid, Medicare, or other benefits for which you may be eligible. If your income is less than the federal poverty guidelines, you will be charged a discounted fee.

2. You have a right to receive explanations of the center's bills. You must pay, or arrange to pay, all agreed fees for medical and dental services. If you cannot pay right away, please let staff know so they can provide care for you now and work out a payment plan.

3. Federal law prohibits the center from denying you primary health care services which are medically necessary solely because you cannot pay for these services.

C. Privacy

You have a right to have your interviews, examinations and treatments in privacy. Your medical records are also private. Only legally authorized persons may see your medical records unless you request in writing for us to show them to, or copy them for, someone else. In certain instances, the center may be required to report to the Pennsylvania Department of State Health Services regarding your health condition or disease status. A complete discussion of your privacy rights will be given to you along with this document and is named the center's Notice of Privacy Practices. Staff will request that you acknowledge your receipt of our Notice of Privacy Practices. The Notice of Privacy Practices sets forth the ways in which your medical records may be used or disclosed by the center and the rights granted to you under the Health Insurance Portability and Accountability Act ("HIPAA").



D. Health Care

1. You are responsible for providing the center complete and current information about your health or illness, so that we can give you proper health care. You have a right, and are encouraged, to participate in decisions about your treatment.

2. You have a right to information and explanations in the language you normally speak and in words that you understand. You have a right to information about your health or illness; treatment plan, including the nature of your treatment; its expected benefits; its inherent risks and hazards (and the consequences of refusing treatment); the reasonable alternatives, if any (and their risks and benefits); and the expected outcome, if known. This information is called obtaining your informed consent.

3. You have the right to receive information regarding "Advance Directives." If you do not wish to receive this information, or if it is not medically advisable to share that information with you, we will provide it to your legally authorized representative.

4. You are responsible for appropriate use of center services, which includes following staff instructions, making and keeping scheduled appointments, and requesting a "walk-in" appointment only when you are ill. Center professionals may not be able to see you immediately unless you have an appointment or it is an emergency. If you are unable to follow instructions from the staff, please tell them so they can help you.

5. If you are an adult, you have a right to refuse treatment or procedures to the extent permitted by applicable laws and regulations. In this regard, you have the right to be informed of the risks, hazards, and consequences of your refusing such treatment or procedures. Your receipt of this information is necessary so that your refusal will be "informed." You are responsible for the consequences and outcome of refusing recommended treatment or procedures. If you refuse treatment or procedures that your healthcare providers believe is in your best interest, you may be asked to sign a Refusal to Permit Medical Treatment or Services form or Against Medical Advice form (as appropriate).

6. You have a right to health care and treatment that is reasonable for your condition and within our capability; however, the center is not an emergency care facility. You have a right to be transferred or referred to another facility for services that the center cannot provide. The center does not pay for services that you receive from another health care provider.

7. If you are in pain, you have a right to receive an appropriate assessment and pain management, as necessary.

E. Center Rules

1. You have a right to receive information on how to appropriately use the center's services. You are responsible for using the center's services in an appropriate manner. If you have any questions, please ask us.

2. You are responsible for the supervision of children you bring with you to the center. You are responsible for your children's safety and the protection of other patients and our property.

3. You have a responsibility to keep your scheduled appointments. Missed scheduled appointments cause delay in treating other patients. If you do not keep scheduled appointments you may be subject to disciplinary action pursuant to the center's policies and procedures.

F. Complaints

1. If you are not satisfied with our services, please tell us. We want suggestions so we can improve our services. Staff will tell you how to file a complaint. If you are not satisfied with how the staff handles your complaint, you may complain to the center's Board of Directors.

2. If you make a complaint, no center representative will punish, discriminate or retaliate against you for filing a complaint, and the center will continue to provide you services.

G. Termination

If the center decides that we must stop treating you as a patient, you have a right to advance written notice that explains the reason for the decision, and you will be given thirty (30) days to find other health care services. However, the center can decide to stop treating you immediately, and without written notice, if you have created a threat to the safety of the staff and/or other patients. You have a right to receive a copy of the center's Termination of the Patient and Center Relationship Policy and Procedure.

Reasons for which we may stop seeing you include:

1. Failure to obey center rules and policies, such as keeping scheduled appointments;
2. Intentional failure to accurately report your financial status;
3. Intentional failure to report accurate information concerning your health or illness;
4. Intentional failure to follow the health care program, such as instructions about taking medications, personal health practices, or follow-up appointments, as recommended by your healthcare provider(s); and/or
5. Creating a threat to the safety of the staff and/or other patients.

H. Appeals

If the center has given you notice of Termination of the Patient and Center Relationship, you have the right to appeal the decision to the Board. Unless you have a medical emergency, we will not continue to see you as a patient while you are appealing the decision.

By: _____ ____/____/____
Date

Name: _____
[Print Name]

If signing for a minor, _____
[Print Minors Name]

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CANCELLATION POLICY

Policy Title: Cancellation/No-Show Policy	Effective (Original) Date: 08/13/2015
Dept./Ops Area: Clinical	Policy Number: CLIN304
Approved by Board: 08/13/2015 Reapproved by Board: 12/21/2017, 8/24/2018, 05/06/2020, 10/14/21, 06/20/2023	Board President Signature Date

BACKGROUND

Patients who fail to keep their appointments interrupt the scheduling process, disrupt the delivery of care, and cost the center both in terms of lost revenue and wasted staff efforts. Understanding, controlling, and eliminating root causes of no-show activity or less than 24-hour notice will allow the health center to gain higher returns from additional activities aimed at improving the efficiency of the organization, predicting and planning for patient flow, and the utilization of center resources.

POLICY

It is the policy of the center to inform patients of the importance of keeping appointments and the expectation that they will call to cancel no less than 24 hours prior to their appointment. Patients receive reminder texts or calls at 48 hours and 36 hours prior to their appointment, notifying them that they must confirm or their appointment may be given to another patient. Under certain conditions, the patient may be prevented from scheduling future appointments and may only be able to make same-day appointments.

PROCEDURE

A. Each patient receives and signs the Patient and Center Rights and Responsibilities form upon registering as a patient of the center and annually, according to the Policy and Procedure Regarding Patient and Center Rights and Responsibilities.

B. Patients that fail to keep or cancel their appointments with less than 24-hour notice three times in a 12-month period, or five times for children under the age 18, may be prevented from scheduling future appointments for a period of six months and will be seen on a same-day or walk-in basis only. The six-month period starts from the date of the last violation of this policy.

C. When scheduling an appointment, the patient or family member is reminded to call and cancel if they will be unable to make the appointment. Staff will verify contact method, email address and phone number before making the appointment. Patients will also be reminded in reminder calls and texts of this policy.

D. For each appointment that the patient does not keep or cancel with at least 24 hours' notice, the patient or parent will receive communication from the center inquiring as to the reason why the appointment was not kept. Such forms of communication could include a telephone call from the center, a letter informing them of the policy and the outcome of their actions, or a text or email communication requesting the patient contact the center. Documentation will be made in the patient's medical/dental record indicating their failure to keep a scheduled appointment, as well as the center's ability to contact them and any consequences of the patient not calling/showing up for their appointment.