LEE SPECIALTY CLINIC

Dear Patients, Families, Guardians, and Care Givers,

Here at the Lee Specialty Clinic, we strive to provide compassionate, interdisciplinary healthcare to patients with intellectual and developmental disabilities and we look forward to providing all of your healthcare needs. In order to provide you with comprehensive care, it is necessary we maintain current and updated health information. Please complete the attached patient packet to initiate care and continual care here at the clinic. This information needs to be completed annually.

In order for us to provide comprehensive care, we are requesting the following items:

1) **Legal guardian to complete New Packet Information for the clinic.**
2) **Copy of guardianship papers or Medical POA documents from court**
3) **Copy of current insurance cards**
4) **Copy of immunization record**
5) **List and dosage of all current medications taken**
6) **Financial statement packet completed and signed in all places**

Please ensure that each page of the patient packet is completed and signed by the patient/legal guardian as required. All medical information needs to be checked and the forms signed. After receiving the completed packet back at the clinic, the Lee Specialty Clinic clinicians will review and sign the documents and you will receive a call to schedule an appointment, therefore, it is important that we receive the packet back timely into the office signed and completed with all documents requested.

If you should have any questions, please do not hesitate to contact our office. We look forward to seeing you soon.

Sincerely,

Tanyika Wan, RHIT, CAO

Tanyika R. Wan, RHIT
Chief Administrative Officer

4501 Louise Underwood Way • Louisville, KY 40216 • Phone: (502) 368-2348 • Fax: (502) 368-2340

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Operated by Chyron, LLC

FACE SHEET

PATIENT INFORMATION		MEDICAL HISTORY
Patient First Name:	Patient Middle Name:	Patient Last Name:
Patient Social Security Number:	Patient Date of Birth:	Patient Gender:
Patient Street Address:	Patient City:	Patient County:
Patient State:	Patient Zip Code:	Patient Race:
Guardian Name: Guardian Address: Guardian Relationship to Patient: Guardian Phone: Guardian Email:	Primary Insurance Company: Primary Insurance Identification Number: Primary Insurance Group Number: Primary Insurance Policy Name: Primary Insurance Phone Number:	Secondary Insurance Company: Secondary Insurance Identification Number: Secondary Insurance Group Number: Secondary Insurance Policy Name: Secondary Insurance Phone Number:
Who should the clinic contact in order to confirm appointments? Contact Name: Contact Email: Contact Phone:	Case Manager Name: Case Manager Address: Case Manager Phone: Case Manager Cell Phone:	Next of Kin Name: Next of Kin Address: Next of Kin Relationship to Patient: Next of Kin Phone:
How did you find out about the Lee Specialty Clinic?	Pharmacy Name and Phone?	Next of Kin Email:
In what setting does the patient live? ☐ With Family ☐ FHP ☐ Staffed Residence ☐ ICF/ID ☐ Independently ☐ Other:	Currently a Special Olympics athlete? ☐ Yes ☐ No Employment Status? ☐ Student ☐ Unemployed ☐ Full-Time ☐ Retired ☐ Part-Time ☐ Other	Day Program Name: Day Program Address: Day Program Phone:
Is the patient his or her own guardian? ☐ Yes ☐ No, **Please attach guardianship papers**	Does the patient have a living will or a do not resuscitate order? ☐ No ☐ Yes, please attach	Does the patient have have a valid Kentucky Power Of Attorney? Is the patier ☐ Yes, please attach
Please check all of the services that are being requested at this time: ☐ Medicine ☐ Psychology ☐ Crisis Intervention ☐ Dentistry ☐ Behavioral ☐ Physical Therapy ☐ Psychiatry ☐ Genetics ☐ Occupational Therapy ☐ Neurology ☐ Nutrition ☐ Speech Therapy ☐ Vision ☐ Hearing ☐ Other, please describe:		Who is your current Primary Care Physician? Do you require the services of a translator? ☐ No ☐ Sign Language ☐ Spanish ☐ Other:

MEDICAL INFORMATION

PAST MEDICAL HISTORY (Attach Additional Information if Necessary)

Please list all known current and prior illnesses (aside from minor injuries or infections).

Does the patient have intellectual disability? ☐ No ☐ Yes: ☐ Mild ☐ Moderate ☐ Severe ☐ Profound

Does the patient have any of the following conditions?

☐ Autism ☐ Cerebral Palsy ☐ Down syndrome ☐ Fetal alcohol syndrome ☐ Fragile X syndrome

Any other known syndrome, please list or describe:

Has the patient had genetic testing? ☐ No ☐ Yes, please state approximately how long ago:

Please list all hospitalizations with date, location and reason for stay.

Date:	Location:	Reason for Stay:

Please list all past surgeries with date, location, reason for surgery and what was done.

Date:	Location:	Reason for Surgery:	What was Done:

Please list any major injuries, accidents, or traumatic events you have experienced in your life.

FAMILY HISTORY

Please tell us about any illnesses that run in the patient's family, include the relationship to the patient and age they were diagnosed.

Relationship	Illness	Age at which relative was diagnosed

Please tell us about any family members with birth defects, genetic disorders or intellectual or developmental disabilities.

SOCIAL HISTORY

Does the patient smoke? ☐ No ☐ Yes, if yes, how much and how often?

Does the patient chew tobacco? ☐ No ☐ Yes, if yes, how much and how often?

Does the patient chew nicotine gum? ☐ No ☐ Yes, if yes, how much and how often?

Does the patient use e-cigarettes? ☐ No ☐ Yes, if yes, how much and how often?

Does the patient drink alcohol? ☐ No ☐ Yes, if yes, how much and how often?

Does the patient drink caffeinated beverages? ☐ No ☐ Yes, if yes, how much and how often?

Does the patient use any street drugs? ☐ No ☐ Yes, if yes, how much and how often?

Has the patient ever been addicted to any substances, including prescriptions? ☐ No ☐ Yes, if yes, please describe.

Is the patient currently sexually active? ☐ No ☐ Yes

ALLERGIES

Is the patient allergic to any of the following:

Medications ☐ No ☐ Yes Latex ☐ No ☐ Yes

Seasonal Allergies ☐ No ☐ Yes Food ☐ No ☐ Yes

Insect bites or stings ☐ No ☐ Yes

Please list what the patient is allergic to and what happens if he or she is exposed to it:

MEDICATIONS (Attach Additional Information if Necessary, Please Include Date Started)

Please list any medications the patient is taking and please include the name, dose and frequency of administration of the medication.

Medication Name	Dose	Frequency	Reason	Medication Name	Dose	Frequency	Reason

If necessary, please attach a list of additional medications to this form.

Please check if the patient has, or has had any of the following:

GENERAL	VISION and HEARING	NOSE, MOUTH, THROAT and NECK
☐ Weight loss	☐ Double vision	☐ Nasal discharge
☐ Weight gain	☐ Vision impairment	☐ Postnasal drip
☐ Fatigue	☐ Eye disorders	☐ Mouth sores
☐ Insomnia	☐ Eye pain	☐ Non-healing mouth ulcers
☐ Sleep disturbances	☐ Red eye	☐ Difficulty swallowing
☐ Pain	☐ Eye discharge	☐ Choking
☐ Fever	☐ Change in hearing	☐ Snoring
☐ Chills	☐ Hearing impairment	☐ Hoarseness or changing in the voice
☐ Difficult wound healing	☐ Ear pain	☐ Neck pain
☐ Problems with daily functions	☐ Ear drainage	☐ Difficulty moving neck
☐ None of the above	☐ None of the above	☐ None of the above

DENTAL	DENTAL CONTINUED	LUNGS
☐ No teeth	☐ Tooth Extraction	☐ Shortness of breath
☐ Metal amalgam fillings	☐ Root canal	☐ Persistent cough
☐ White composite fillings	☐ Braces	☐ Asthma
☐ Dental cleanings in the past	☐ Grind teeth	☐ Wheezing
☐ Dental crowns	☐ Use a bite guard	☐ Aspiration
☐ Dental caps	☐ Any painful teeth	☐ History of pneumonia
☐ Dental bridge	☐ Any loose teeth	☐ COPD or emphysema
☐ Dentures	☐ Tooth sensitivity to hot or cold	☐ Tuberculosis
☐ Partial dentures	☐ Tooth sensitivity to sweets	☐ Frequent respiratory infections
☐ None of the above	☐ None of the above	☐ None of the above

HEART	GENITOURINARY and REPRODUCTIVE	GASTROINTESTINAL
☐ Shortness of breath while lying down	☐ Current pregnancy	☐ Cannot eat by mouth
☐ Lightheadedness / dizziness	☐ Prior pregnancy	☐ Needs assistance eating
☐ Palpitations	☐ Polycystic ovarian syndrome	☐ Acid reflux, heartburn or GERD
☐ Heart murmur	☐ Low testosterone	☐ Hiatal hernia
☐ Heart attack	☐ Kidney stones	☐ Ulcers
☐ Congenital heart defect	☐ Cancer of the kidney or bladder	☐ Colitis
☐ Chest pain or pressure	☐ Cancer of any reproductive organs	☐ Nausea
☐ Coronary artery disease	☐ Any infection of the reproductive organs	☐ Vomiting
☐ High cholesterol	☐ Loss of bladder control	☐ Diarrhea
☐ High blood pressure	☐ Indwelling catheter	☐ Constipation
☐ Loss of consciousness	☐ Urostomy	☐ Blood in vomit
☐ Heart infection	☐ Sexually transmitted diseases	☐ Blood in stool
☐ None of the above	☐ None of the above	☐ None of the above

Please describe any items checked above (you may provide attach additional documents to this form):

Please check if the patient has, or has had any of the following:

ABDOMINAL	NEUROLOGICAL	ENDOCRINE and METABOLIC
☐ Abdominal pain	☐ Headache	☐ Diabetes
☐ Jaundice	☐ Seizures	☐ Thyroid disorder
☐ Hepatitis	☐ Impaired coordination or balance	☐ Adrenal gland disorder
☐ Other liver disease	☐ Weakness or paralysis	☐ Growth hormone deficiency
☐ Pancreatitis	☐ Spastic muscles	☐ Pheochromocytoma
☐ Gallbladder disease	☐ Difficulty with movement	☐ Pituitary adenoma
☐ Any type of intestinal disease	☐ Hydrocephalus	☐ Other endocrine tumors
☐ Enlarged spleen	☐ Shunt	☐ Vitamin deficiency
☐ Appendicitis	☐ Concussion	☐ Hormone therapy
☐ None of the above	☐ None of the above	☐ None of the above
MUSCULOSKELETAL	**SKIN, HAIR, NAILS and BREASTS**	**PSYCHIATRIC / BEHAVIORAL**
☐ Artificial joint(s)	☐ Rash	☐ Impulsivity
☐ Arthritis	☐ Skin cancer	☐ Obsessive Compulsive Disorder (OCD)
☐ Scoliosis	☐ Skin sores	☐ Attention Deficit/Hyperactivity (AD/HD)
☐ Gout	☐ Itching or pain in skin	☐ Anxiety
☐ Osteoporosis	☐ Psoriasis	☐ Panic attacks
☐ Fractures	☐ Eczema	☐ Depression
☐ Muscular dystrophy	☐ Hair loss or brittle hair	☐ Schizophrenia
☐ Myasthenia gravis	☐ Ectodermal dysplasia	☐ Hallucinations
☐ Fibromyalgia	☐ Problems with nails of hand or feet	☐ Self Injurious Behavior (SIB)
☐ Osteogenesis imperfecta	☐ Breast pain	☐ Aggressive behavior (physical or verbal)
☐ Spina Bifida	☐ Breast lumps	☐ Property destruction
☐ Any other muscle or bone disorder	☐ Breast discharge	☐ Other:
☐ None of the above	☐ None of the above	☐ None of the above
IMMUNOLOGICAL	**HEMATOLOGICAL and VASCULAR**	**USE OF IMMOBILIZATION**
☐ Seasonal allergies	☐ Easy bleeding	☐ Use of mouth prop
☐ Any autoimmune disease	☐ Sickle cell anemia or trait	☐ Weighted blanket
☐ Rheumatic fever	☐ Any type of anemia	☐ Use of wrist wrap
☐ HIV/AIDS	☐ Any type of blood disorder	☐ Use of lap belt
☐ Any chronic infection	☐ History of blood clots	☐ Use of papoose
☐ Cancer, tumors or growths	☐ Swelling in the legs	☐ Oral sedation
☐ Chemotherapy	☐ Lower leg pain when walking	☐ In-office I.V. sedation
☐ Radiation therapy	☐ Stroke	☐ General anesthesia in operating room
☐ None of the above	☐ None of the above	☐ None of the above

Please describe any items checked above:

ASSISTIVE/IMPLANTED DEVICES

☐ G-tube	☐ Walker	☐ Glasses or contacts	☐ Spinal rod	☐ Communication device
☐ J-Tube	☐ Crutches	☐ Hearing aid	☐ Pacemaker	☐ Removable prosthetic
☐ Colostomy	☐ Wheelchair	☐ Inhaler	☐ C-PAP machine	☐ Vagus Nerve Stimulator

Signature _____ Date _____

Print name of person signing above and relationship to the patient _____ Date _____

FOR OFFICIAL USE ONLY

Clinician Signature and Date _____

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Phone: (502) 368-2348 Fax: (502) 368-2340

CONSENTS AND NOTIFICATIONS

Patient Name: _____ **Patient Date of Birth:** _____

Consent for Examination, Evaluation and Treatment

Consent. On behalf of the above-named patient, I hereby give my permission for the Lee Specialty Clinic clinicians, or any clinician designated by the Lee Specialty Clinic to perform medical, dental, psychiatric, behavioral, neurological, therapeutic and/or any other health related procedures offered by the clinic including, but not limited to: examination, diagnostic procedures such as photographic and video-based procedures, x-rays, laboratory testing, treatment and/or therapies.

I understand that examination or treatment of any patient embodies some level of risk for injury, up to and including death. I also understand that examination and treatment of a patient with intellectual and/or developmental disability (IDD) involves additional risks unique to this patient population. I also understand that there are risks associated with not examining and/or not treating problems identified by Lee Specialty Clinic clinicians.

I understand that no outcome can be absolutely predicted or guaranteed as a result of treatment received, and I affirm that the Lee Specialty Clinic has made no such prediction or guarantee.

Use of Anesthesia / Prescription Medication. I understand that some procedures done in the clinic requiring the use of anesthesia will involve local anesthesia. I understand that, should a referral to a hospital program, or should the utilization of IV sedation or general anesthesia be required to safely examine and treat, I will be informed and involved in the decision-making process.

I understand that the use of local anesthesia, or any medication that the clinician may prescribe, carries with it some inherent risks including, but not limited to previously undiagnosed drug allergy. I also understand that there are risks associated with not utilizing local anesthesia or other prescription medications.

I understand that, during the course of my treatment, certain controlled substances (medications) may be prescribed, and that the risks associated with the use of these types of medications may include but not be limited to: nausea, vomiting, drug allergy, drug tolerance, and drug dependence.

More Complicated Procedures. I understand that, should more complicated procedures such as tooth extractions, gingival (gum) surgeries, biopsies, suturing of small lacerations or other procedures be indicated, I may be required to give additional written consent to these specific procedures.

Emergency Treatment. In case of emergency situations including but not limited to fractures of teeth / bones, acute infections, respiratory distress, or situations in which the clinician deems that severe pain or patient harm is either present or imminent, I give my permission for the clinician to provide the limited emergency treatment he / she deems appropriate to resolve the emergency situation.

Authorization to Film and Photograph

I hereby give permission for the Lee Specialty Clinic to photograph or take videos of the above-named patient. I understand that these images will be used only for teaching purposes or for educational, informative or promotional materials that are intended to improve the quality of health care available to people with intellectual disabilities or developmental disabilities. I understand that, under no circumstances, will these photographs be sold to a third party. I also understand that the name of the above-named patient will not be revealed in any public forum outside the clinic facility without permission.

Consent to Utilize Medical Immobilization

General Consent. I hereby give my permission for any Lee Specialty Clinic clinician, or any clinician he / she may designate, to utilize temporary medical immobilization (mouth prop, wrist wraps or papoose) during the delivery of services to the above-named patient, should the clinician deem it necessary for the safe delivery of care.

Associated Risks. I understand that the use of temporary medical immobilization embodies some level of risk for possible injury to the above-named patient. However, I also understand that there are risks associated with not using medical immobilization (e.g. risk of self-injury, etc.).

Medical Immobilization Policy. Our primary responsibility to our patients is to provide quality medical, dental, psychiatric, behavioral, psychological, neurological, audiological, ophthalmological, therapeutic and other healthcare services in a safe environment.

Living up to this responsibility requires vigilance in areas that include: that instruments are sterile, that equipment is clean, and that the clinic is properly maintained. Safe and vigilant care also includes conducting an examination, developing an accurate diagnosis, and writing an individualized treatment plan. Equally important is our responsibility to protect our patients with intellectual disabilities from self-injury during the delivery of care. A basic creed, adhered to by all clinicians is “Do no harm.”

Patients who either lack the ability to control their body movements or lack sufficient cognitive functioning to understand that their body movements may interfere with the performance of a procedure and in so doing may cause injury to themselves should have their movements managed in such a way as to prevent that self-injury.

In situations where the clinician determines that self-injury is likely, he or she, as the professional charged with that patient's well being, *must* live up to his or her responsibility to provide for the patient's safety. The patient has a fundamental right to this level of safety.

The level of medical immobilization employed should be the least restrictive, effective method necessary to safely deliver care. Though, it is important to note that what constitutes the least restrictive, effective method may change based on the clinical judgment of the clinician. The *Clinic Hierarchy of Medical Immobilization Intervention* describes, from most passive to most aggressive, what those levels of intervention involve.

Clinic Hierarchy of Medical Immobilization Intervention:

1) Gentle hand holding / re-directing of hand movements
2) Mouth prop to limit mouth movement
3) Wrist wrap to limit upper limb movement
4) Papoose wrap to limit body movement
5) Oral sedation
6) IV sedation
7) Referral to the operating room for general anesthesia and endotracheal intubation.

The following section, *The Patient's Right to Freedom of Movement* addresses the clinician's legal considerations; and *The Patient's Right to Safety* discusses the medical considerations the clinician faces when deciding whether or not to employ medical immobilization.

The Patient's Right to Freedom of Movement. All patients served by the Lee Specialty Clinic have a fundamental right to human dignity and privacy. Freedom of movement is an important part of both dignity and privacy. Many of the patients seen at the Lee Specialty Clinic have had a person other than themselves designated by the Court as being their legal representative.

When obtaining consent to utilize medical immobilization, the Lee Specialty Clinic provides the patient's legal representative with an opportunity to ask questions about medical immobilization and to have his or her questions answered in language he or she understands.

The Patient's Right to Safety. Many patients can be safely examined and treated in the clinic with no medical immobilization intervention being required. As has been stated, utilization of medical immobilization is sometimes indicated in an effort to promote the safe delivery of care.

However, in cases where the patient is severely resistant to examination and treatment, the clinician may determine that further attempts to examine, treat, or to utilize medical immobilization is unsafe; and that the process itself represents a risk of injury to the patient. These cases will be referred for treatment in the operating room under general anesthesia and endotracheal intubation.

The use of medical immobilization is one of many issues constantly being evaluated when delivering care to patients. Decisions regarding patient positioning, positioning of the chair, or use of a mouth prop are, in many ways, related to improving patient safety and comfort. It is critical that these decisions remain very *patient*-centered, and that they remain subject to revision, as clinical realities evolve and change.

Notification: What You Should Know About HIV and AIDS

AIDS is Acquired Immune Deficiency Syndrome- a serious illness which makes the body unable to fight infection. A person with AIDS is susceptible to certain infections and cancers. When a person with AIDS cannot fight off infections this person becomes ill. Most people with AIDS will die as a result of their infection. AIDS is caused by a virus called Human Immunodeficiency Virus, or HIV. Early diagnosis of HIV infection is important! If you have been told you have HIV, you should get prompt medical treatment. In many cases, early treatment can enhance a person's ability to remain healthy as long as possible. Your doctor will help you determine the best treatment for you. Free anonymous and confidential testing and counseling is available at every health department in Kentucky. After being infected with HIV, it takes between two weeks and six months before the test can detect the antibodies to the virus.

HIV Can Be Spread By:

1) Sexual contact (oral, anal, or vaginal intercourse) with an infected person when blood, semen or cervical/vaginal secretions are exchanged

2) Sharing a syringe/needle with someone who is infected

3) Receiving contaminated blood or blood products (very unlikely now because blood used in transfusions has been tested for HIV antibodies since March 1985)

4) An infected mother passing HIV to her unborn child before or during childbirth, and through breast feeding

5) Receipt of transplant or infected tissue/organs or artificial insemination from an infected donor

6) A needle stick or sharps injury in a health care setting involving an infected person

You Cannot Get HIV Through Casual Contact Such As:

1) Sharing food, utensils, or plates

2) Touching someone who is infected with HIV

3) Hugging or shaking hands

4) Donating blood (this has never been a risk for contracting HIV)

5) Using public rest rooms

6) Being bitten by mosquitoes or any other insect

Prevention:

1) Do not share needles or syringes with anyone

2) Do not have sexual intercourse except with a monogamous partner whom you know is not infected. If you choose to have sex with anyone else, use latex condoms (rubbers), female condoms or dental dams every time you have sex

3) Educate yourself and others about HIV infection and AIDS.

You Should Be Tested If You:

1) Have had sex with someone who has HIV

2) Have had sex with someone who has or has had any sexually transmitted disease (STD)

3) Have shared needles with or syringes with someone who has HIV

4) Have had multiple sex partners or you have had sex with someone who has had multiple partners

5) Have had sex through prostitution (male or female)

6) Have had sex with injecting drug users

7) Had a blood transfusion between 1978 and 1985

8) Are a woman who is pregnant or desires to be pregnant and who wishes to reduce the chance of your baby getting HIV from you should you be infected

How to Use a Latex Condom:

1) Use a new latex condom every time you have sex.

2) The condom should be rolled onto the erect (hard) penis, pinching ½ inch at the tip of the condom to hold the ejaculation (semen) fluid. Air bubbles should be smoothed out.

3) Use plenty of Water-Based lubricants such as K-Y Jelly, including a drop or two inside the condom, before and during intercourse. Do Not Use oil-based lubricants such as petroleum jelly, mineral oil, Crisco, or cold cream.

4) After ejaculating, withdraw the penis holding the condom at the base so it will not slip off.

5) Throw away the used condom and wash hands.

If You Need More Information, Please Call:

Kentucky HIV/AIDS Education Program (502) 564-6539; (Voice/TTY) (502) 564-6539

Kentucky AIDS Hotline 1-(800)840-2865 or the National AIDS Hotline 1(800)342-AIDS

Your local health department's HIV/AIDS Coordinator

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 9/1/2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

1) Prevent or control disease, injury or disability;
2) Report abuse or neglect;
3) Report reactions to medications or problems with products or devices;
4) Notify a person of a recall, repair, or replacement of products or devices;
5) Notify a person who may have been exposed to a disease or condition; or
6) Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Worker's Compensation. We may disclose your Personal Health Information (PHI) to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized or permitted by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Education. We may disclose your health information to others, with redactions as to all personal identifying information, for the purposes of training, education, quality assurance/improvement, and other such related activities.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may

provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Tanyika Wan, RHIT
Chief Administrative Officer
4501 Louise Underwood Way
Louisville, KY 40216
Phone: (502)368-2348 Phone
(502)368-2340 Fax
Email: TanyikaWan@admed.us

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the practice's Privacy Official/Administrative Director at 4501 Louise Underwood Way, Louisville, KY 40216. If I revoke this authorization, my revocation will not affect any actions taken by the practice before receiving my written revocation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires on the following date, or when the following event occurs: _____

Authorization for Use and/or Disclosure of Patient Health Information

I hereby authorize the use and disclosure of the patient information as described in the *Notice of Privacy Practices*. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations. In addition, you may authorize, below, specific individuals to whom PHI may be released. If necessary, please list other recipients on the back of this form.

Name: _____

Relationship: _____

Type of Information to be released:

☐ Diagnosis ☐ Plan of Care

☐ Payment ☐ Other:

Name: _____

Relationship: _____

Type of Information to be released:

☐ Diagnosis ☐ Plan of Care

☐ Payment ☐ Other:

Name: _____

Relationship: _____

Type of Information to be released:

☐ Diagnosis ☐ Plan of Care

☐ Payment ☐ Other:

Name: _____

Relationship: _____

Type of Information to be released:

☐ Diagnosis ☐ Plan of Care

☐ Payment ☐ Other:

Confirmations and Signatures

Patient Name: _____ **Patient Date of Birth: _____**

I attest that the information provided in the above named patient's MEDICAL INFORMATION is true and complete to the best of my knowledge. I understand and agree that the information I am providing will be relied upon by the Lee Specialty Clinic. I affirm that I have received and read the *Consent for Examination, Evaluation and Treatment*, the *Authorization to Film and Photograph*, the *Consent to Utilize Medical Immobilization*, *Notification: What You Should Know About HIV and AIDS*, and the *Notice of Privacy Practices*.

Please check your consent for the following:

☐Yes	☐No	I give my consent to the Lee Specialty Clinic to examine, evaluate and treat the above named patient.
☐Yes	☐No	I give my consent to the Lee Specialty Clinic to film and/or photograph the above named patient.
☐Yes	☐No	I give my consent to the Lee Specialty Clinic to utilize medical immobilization as described above.
☐Yes	☐No	I give my consent to the Lee Specialty Clinic to obtain, use and share the personal health information of the above named patient.
☐Yes	☐No	I give my consent to the Lee Specialty Clinic to obtain the personal health information of the above named patient from other treating healthcare providers.
☐Yes	☐No	I give my consent to the Lee Specialty Clinic to submit claims to, and receive payment from the insurance carrier of the above named patient for all professional services received.

_____ _____

Signature of Patient's Legal Representative Date

_____ _____

Name of Patient's Legal Representative (Please Print) Relationship to the Patient

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify):

REVIEWED BY:

_____

Signature and Date

LEE SPECIALTY CLINIC

Operated by Chyron, LLC

4501 Louise Underwood Way, Louisville, KY 40216
Phone: (502) 368-2348 Fax: (502) 368-2340

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH CARE INFORMATION

TO: _____

_____

_____

_____

The following applies to the Health Insurance Portability and Accountability Act Privacy Regulations pursuant to 45 CFR §164.5

The above named provider is hereby authorized to release to **LEE SPECIALTY CLINIC**, or any of its representatives, all medical, mental health, and dental records including all diagnostic testing and HIV-related records, concerning any medical treatment that the patient named below has received from you or at your institution. A photostatic copy hereof shall be as valid as the original authorization.

The following applies to disclosure of alcohol or drug services whose confidentiality is protected by Federal Law 42 U.S.C. §§ 290dd-22.

The above named provider is hereby authorized to release to **LEE SPECIALTY CLINIC**, or any of its representatives, all medical, mental health, and dental records including all diagnostic testing and HIV-related records relating to any treatment or services that the patient named below may have received from you or at your institution related to alcohol and/or drug/chemical dependency. A photostatic copy hereof shall be as valid as the original authorization.

The purpose of this Authorization and request is to obtain medical, mental health or dental records which may be relevant as it pertains to the medical evaluation and/or treatment of the patient named below. The requested information is the minimum information needed in connection with the evaluation and/or treatment of the patient. I have the right to revoke this Authorization in writing by providing a signed, written notice of revocation to you and **LEE SPECIALTY CLINIC**.

The above named provider may not condition treatment or payment on whether this Authorization is executed. The information disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act. Any revocation of the Authorization is not effective with respect to actions a covered entity took in reliance on a valid Authorization and therefore, shall not apply to records produced by a covered entity prior to revocation. This Authorization is effective for two (2) years from the date of signing.

PATIENT NAME: _____ SIGNATURE: _____

SOCIAL SECURITY NUMBER: _____ PRINTED NAME: _____

DATE OF BIRTH: _____ LEGAL RELATIONSHIP TO PATIENT: _____

DATE OF SIGNATURE: _____

LEE SPECIALTY CLINIC

COMMONWEAL TH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES

OUTPATIENT OR RESPONSIBLE PARTY FINANCIAL RECORD

Note: Page one of the Financial Record form Is to be prepared to determine an outpatient client's Ability to Pay when Medicaid coverage does not exist any payment sources such as other health Insurance coverages and secondary payor payments should be first to applied to the cost of services before determining any outpatient client Ability to Pay amount If patient has Medicaid coverage, please continue on to page number two in lieu of filling out the above, since Medicaid will have already made such a determination and established payment requirements associated with outpatient specialty clinic services at this facility.

Name _____ Social Security Number _____
Last First Middle

Date Completed _____

1. Family Members — Gross Income
(Check applicable boxes)

☐ Self (outpatient) Salary Income	$ _____	*Current or Last Employer: _____
☐ Other Responsible Person	$ _____	Other Responsible Person Name: _____
☐ Social Security	$ _____	
☐ Veteran's Adm.	$ _____	
☐ Company Pension	$ _____	
☐ Other (describe)	$ _____	_____
Total Income	_____	(NOTE: Gross Income Which will continue during treatment and after discharge of patient)

2. Financial Assets

	Amount	Remarks
Savings Account	$ _____	
Bank _____		
Value of Stocks & Bonds	_____	
Checking Account Balance	_____	
Bank _____		
Other _____	_____	
Asset Total	$ _____	

3. Social Security and Income Taxes

Social Security Taxes	_____
State Income Taxes	_____
Federal Income Taxes	_____
Total Taxes Deduction	_____ ^

4. Unpaid Medical/Dental Bills

	Names	Unpaid Bills	Month/Year Incurred
State Facilities	_____	$ _____	_____
Hospitals	_____	_____	_____
Clinics	_____	_____	_____
Physicians	_____	_____	_____
Dentists	_____	_____	_____

Total Medical Bills Deduction $ _____

$ Extraordinary and involuntary expenses, such as payments for tools of trade; tuition, books and board for vocational education or college; and alimony and/or child maintenance as mandated by the Courts: (Justify on an annual basis)

Total Extraordinary and Involuntary expenses $ _____

FOR OFFICE USE ONLY

Net Income subject to Ability to Pay for Outpatient Services $ _____

Outpatient Income Sliding Fee Family Size Amount $ _____

Net Income Outpatient Ability to Pay Amount $ _____ **Applicable Income Sliding Fee %** _____

Net Assets subject to Ability to Pay for Outpatient Services $ _____

Outpatient Assets Sliding Fee Protected Amount $ _____

Net Assets Outpatient Ability to Pay Amount $ _____

* Annual Salary and Wages
^ Social Security and Income Taxes may be estimated to total 25% of total income in lieu of actual tax values withheld or paid.

OUTPATIENT INSURANCE BENEFITS

List any insurance which covers the patient, such as hospital, health, accident, disability, annuity; including group, and individual policies.

Insurance (Name, Address) If none, write "NA"	Subscriber's Name	Policy No.	Group No.	Effective Date
1.				
2.				

Medicare No. A ☐ B ☐ (check applicable boxes)	Med. Assistance No.	Other (specify)	Social Security No. of Policy Holder(s)
			___ ___ ___ ___ ___ ___ ___ ___ ___

Based upon the above financial date, insurance benefits, and other available coverage establish the patient's maximum ability to pay utilizing the applicable outpatient "Ability to Pay-Guidelines and Tables".

I hereby certify that the financial information submitted and recorded as of this date, , _____ 20 _____ , on this PATIENT OR RESPONSIBLE PARTY FINANCIAL RECORD is complete and true to the best of my knowledge.

It is further understood that the Cabinet for Health and Family Services may void the accompanying FINANCIAL AGREEMENT if any financial information is found to be inaccurate or misleading, and I may be subject to penalties imposed by the Kentucky Revised Statutes.

_____

Signature of Patient or Responsible Party(s)

_____

Relationship to Patient

WORKSHEET NOTES

LEE SPECIALTY CLINIC

COMMONWEAL TH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES

OUTPATIENT OR RESPONSIBLE PARTY FINANCIAL AGREEMENT AND ASSIGNMENT

PATIENT NAME_____ SOCIAL SECURITY NUMBER _____

I. The outpatient clinic service fee charge schedule has been provided to me and those fees are subject to change by the Secretary of Cabinet for Health and Family Services without prior notice.

II. I hereby assign any insurance benefits and other available coverage to the above named health facility, and authorize the release of necessary information for the health facility to file benefit claim(s).

_____ x _____
Date Signature of Patient and/or Responsible Party

_____
If Responsible Party, please list Relationship to Patient

III. I acknowledge financial responsibility in accordance with KRS 210.720 for services rendered or to be rendered to self or _____ a patient at Lee Specialty Clinic.

IV. A. I agree to be responsible for the payment of charges for services rendered during any visit to the specialty clinic based upon my ability to pay in accordance with a “means test” promulgated by the Secretary of the Cabinet for Health and Family Services as outlined by KRS 210.720. It is further understood that any changes income in income (increase or decrease) may alter my ability to pay.

B. Payment of ability to pay will be after available MEDICARE, MEDICAID, Insurance and other benefits have been applied to my charges.

V. I, or we, the undersigned understand the terms of this agreement and acknowledge receipt of a copy.

x _____

x _____
Signature of Patient and/or Responsible Party(s) Relationship to Patient Date

VI. Failure to provide the necessary information to determine the ability to pay may result in the patient being charged FULL PAY for all services rendered by the facility.

Approved and Witnessed by _____
Authorized Representative Date