



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 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 the following New Patient Information paperwork for the clinic.**
- 2) Copy of guardianship papers or Medical POA documents from court, if applicable**
- 3) Copy of current insurance cards**
- 4) Copy of immunization record**
- 5) List and dosage of all current medications taken with dosage and administration instructions (including all over the counter and prn medication)**
- 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 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,

*Hayli Potts*  
*Patient Care Specialist*

*502 358 2348 Ext 2203*



# LEE SPECIALTY CLINIC

## GUIDELINES FOR RECEIVING CARE AT LEE SPECIALTY CLINIC

Welcome to Lee Specialty Clinic! We are glad you are here.

We look forward to taking care of your healthcare needs.

1. Please always bring the patient's medications, insurance cards, and basic demographic information to every appointment. (A medication list, medication administration record, or prescription bottles are all acceptable).
2. If the patient is not their own guardian, then the caregiver/guardian must accompany the patient throughout their Medical clinic visit\*.  
\*For safety reasons, under the discretion of the provider, only patients are permitted in the dental department for their appointments.
3. Please make sure the person bringing the patient knows why he/she is being seen, can give a summary of the patient's history and any recent updates. The person accompanying the patient needs to be knowledgeable about the patient and not just a driver.
4. Please note, for quality and continuity of care; patient after visits/care instructions and summary will be given to the caregiver present for the patient's visit.
5. The patient must arrive at least 15 minutes prior to their scheduled appointment time.
6. If patients arrive after their scheduled appointment time, they will likely be rescheduled.
7. Please call our office to cancel appointments at least 72 hours' before the appointment. Failing to give at least 24 hours notice of cancellation will result in a "no call/no show". Patients may be discharged after 3 no call/no show appointments.
8. For all patient care questions or prescription refills, please dial our main clinic number (502) 368-2348 and request to speak to the nursing staff. For Dental questions or refills, request to speak to the dental department. If you leave a message, we will return your call within 24 hours.
9. We require at least 3 business days' (excluding holidays and weekends) notice for all prescriptions or paperwork. We do not do same day refill or paperwork requests.
10. A convenient and preferred way to request refills is to ask the pharmacy to fax us a refill request.
11. Dental premedication prescription requests must be received at least 3 business days prior to appointment.
12. All dental patients requiring premedication must bring in the written date and time of medication administration to the appointment.
13. Patients with heart murmurs who refuse pretreatment with antibiotics must have written cardiac clearance from their cardiologist prior to receiving dental care.
14. Please notify the clinic anytime there are any changes in contact information, guardianship, or housing / living arrangements.
15. Paperwork must be updated yearly. Patient paperwork that is out of date or incomplete may require the patient's status to be brought to a Lee Specialty Clinic Committee for review and the patient may be discharged from the clinic.
16. When transferring care to Lee Specialty Clinic, please obtain old records from previous providers.
17. For identification purposes every patient will have their picture taken.

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PARENT/ GUARDIAN/CAREGIVER/PATIENT SIGNATURE

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DATE:



Patient Name: \_\_\_\_\_

FACE SHEET

PATIENT INFORMATION		MEDICAL HISTORY
Patient First Name:	Patient Middle Name:	Patient Last Name:
Patient Preferred Name:	Patient Date of Birth:	Patient Gender: Preferred Gender:
Patient Social Security Number:	Patient Street Address:	Patient City: and state Patient Zip Code:
Patient phone:	Patient Race:	
Is the patient his or her own guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No, <b>Please attach guardianship papers</b>	Emergency contact:	Case Manager Name:
Guardian Name:	Relationship	Company Name:
Address:	Address:	Address:
City, State,Zip:	City, State,Zip	City, State,Zip
Phone:	Phone/email:	Phone/email:
Guardian Email:	Primary Insurance Company:	Secondary Insurance Company:
	Primary Insurance Identification Number:	Secondary Insurance Identification Number:
Who should the clinic contact in order to confirm appointments? Contact Name:	Primary Insurance Group Number:	Secondary Insurance Group Number:
Relationship:	Primary Insurance Policy Name:	Secondary Insurance Policy Name:
Contact Email:	Primary Insurance Phone Number:	Secondary Insurance Phone Number:
Contact Phone:	Currently a Special Olympics athlete? <input type="checkbox"/> Yes <input type="checkbox"/> No	Day Program Name:
Is patient on a Medicaid waiver? <input type="checkbox"/> HCB <input type="checkbox"/> SCL <input type="checkbox"/> MPW <input type="checkbox"/> Other _____	Employment Status: <input type="checkbox"/> Student <input type="checkbox"/> Unemployed <input type="checkbox"/> Full-Time <input type="checkbox"/> Retired <input type="checkbox"/> Part-Time <input type="checkbox"/> Other	Day Program Address:
In what setting does the patient live? <input type="checkbox"/> With Family <input type="checkbox"/> FHP <input type="checkbox"/> Staffed Residence <input type="checkbox"/> ICF/ID <input type="checkbox"/> Independently <input type="checkbox"/> Other: Name of Provider: _____ Phone Number: _____	Does the patient have a living will or a do not resuscitate order? <input type="checkbox"/> No <input type="checkbox"/> Yes, please attach	Day Program Phone:
		Does the patient have a valid Kentucky Power Of Attorney? <input type="checkbox"/> Yes, please attach <input type="checkbox"/> No
		Do you require the services of a translator? <input type="checkbox"/> No <input type="checkbox"/> Sign Language <input type="checkbox"/> Spanish <input type="checkbox"/> Other:
Please check all of the services that are being requested at this time: <input type="checkbox"/> Medicine <input type="checkbox"/> Dentistry <input type="checkbox"/> Psychiatry		Pharmacy Name and Phone:
Please Note that all patients require a medical evaluation in order to receive other services		How did you find out about the Lee Specialty Clinic?

## MEDICAL INFORMATION

	Providers Name	City,State	Phone #
PCP	_____	_____	_____
Neurologist	_____	_____	_____
Psychiatrist	_____	_____	_____
Cardiologist	_____	_____	_____
Dentist	_____	_____	_____
Other	_____	_____	_____

### 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 age: \_\_\_\_\_ What were findings: \_\_\_\_\_

### 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 Please (✓) if the answer is yes

Does/Is the patient

- smoke If yes, how often?
- chew tobacco If yes, how often?
- chew nicotine gum? If yes, how often?
- use e-cigarettes? If yes, how often?
- drink alcohol? If yes, how often?
- drink caffeinated beverages? If yes, how often?
- use any street drugs? If yes, how often?
- Addicted to any substances, including prescriptions?    Please describe \_\_\_\_\_
- sexually active?

### ALLERGIES

<p>Is the patient allergic to any of the following:</p> <p style="margin-left: 20px;">Medications    <input type="checkbox"/> No    <input type="checkbox"/> Yes    Latex    <input type="checkbox"/> No    <input type="checkbox"/> Yes</p> <p style="margin-left: 20px;">Adhesive    <input type="checkbox"/> No    <input type="checkbox"/> Yes    Food    <input type="checkbox"/> No    <input type="checkbox"/> Yes</p> <p style="margin-left: 20px;">Insect bites or stings    <input type="checkbox"/> No    <input type="checkbox"/> Yes</p>	<p>Please list what the patient is allergic to and what happens if he or she is exposed to it:</p>
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Please check if the patient has, or has had any of the following:

GENERAL	VISION AND HEARING	NOSE, MOUTH, THROAT and NECK
<input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain <input type="checkbox"/> Fatigue <input type="checkbox"/> Insomnia <input type="checkbox"/> Sleep disturbances <input type="checkbox"/> Pain <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Difficult wound healing <input type="checkbox"/> Problems with daily functions <input type="checkbox"/> None of the above <input type="checkbox"/> Other _____	<input type="checkbox"/> Double vision <input type="checkbox"/> Vision impairment <input type="checkbox"/> Eye disorders <input type="checkbox"/> Eye pain <input type="checkbox"/> Red eye / discharge <input type="checkbox"/> Change in hearing <input type="checkbox"/> Hearing impairment <input type="checkbox"/> Ear pain / drainage <input type="checkbox"/> Nonverbal <input type="checkbox"/> Glasses / Contacts <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Has Communicative Device <input type="checkbox"/> None of the above <input type="checkbox"/> Other _____	<input type="checkbox"/> Nasal discharge <input type="checkbox"/> Postnasal drip <input type="checkbox"/> Mouth sores <input type="checkbox"/> Non-healing mouth ulcers <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Choking <input type="checkbox"/> Snoring <input type="checkbox"/> Hoarseness or changing in the voice <input type="checkbox"/> Neck pain <input type="checkbox"/> Difficulty moving neck <input type="checkbox"/> None of the above <input type="checkbox"/> Other _____
DENTAL	DENTAL CONTINUED	LUNGS
<input type="checkbox"/> No teeth <input type="checkbox"/> Metal amalgam fillings <input type="checkbox"/> White composite fillings <input type="checkbox"/> Dental cleanings in the past <input type="checkbox"/> Dental crowns / Caps <input type="checkbox"/> Dental Implants <input type="checkbox"/> Dentures <input type="checkbox"/> Partial dentures <input type="checkbox"/> None of the above <input type="checkbox"/> Other _____	<input type="checkbox"/> Tooth Extraction <input type="checkbox"/> Root canal <input type="checkbox"/> Braces <input type="checkbox"/> Grind teeth <input type="checkbox"/> Use a bite guard <input type="checkbox"/> Any painful teeth <input type="checkbox"/> Any loose teeth <input type="checkbox"/> Tooth sensitivity to hot or cold <input type="checkbox"/> Tooth sensitivity to sweets <input type="checkbox"/> None of the above <input type="checkbox"/> Other _____	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Persistent cough <input type="checkbox"/> Asthma / Wheezing <input type="checkbox"/> CPAP Machine <input type="checkbox"/> Aspiration <input type="checkbox"/> Uses Inhaler <input type="checkbox"/> History of pneumonia <input type="checkbox"/> COPD or emphysema <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Frequent respiratory infections <input type="checkbox"/> None of the above <input type="checkbox"/> Other _____
HEART	GENITOURINARY and REPRODUCTIVE	GASTROINTESTINAL
<input type="checkbox"/> Shortness of breath while lying down <input type="checkbox"/> Lightheadedness / dizziness <input type="checkbox"/> Palpitations <input type="checkbox"/> Heart murmur <input type="checkbox"/> Pacemaker <input type="checkbox"/> Heart attack <input type="checkbox"/> Congenital heart defect <input type="checkbox"/> Chest pain or pressure <input type="checkbox"/> Coronary artery disease <input type="checkbox"/> High cholesterol <input type="checkbox"/> High blood pressure <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Heart infection <input type="checkbox"/> None of the above <input type="checkbox"/> Other _____	<input type="checkbox"/> Current pregnancy <input type="checkbox"/> Prior pregnancy <input type="checkbox"/> Polycystic ovarian syndrome <input type="checkbox"/> Low testosterone <input type="checkbox"/> Kidney stones <input type="checkbox"/> Cancer of the kidney or bladder <input type="checkbox"/> Cancer of any reproductive organs <input type="checkbox"/> Any infection of the reproductive organs <input type="checkbox"/> Loss of bladder control <input type="checkbox"/> Indwelling catheter <input type="checkbox"/> Urostomy <input type="checkbox"/> Sexually transmitted diseases <input type="checkbox"/> None of the above <input type="checkbox"/> Other _____	<input type="checkbox"/> Cannot eat by mouth <input type="checkbox"/> Needs assistance eating <input type="checkbox"/> Acid reflux, heartburn or GERD <input type="checkbox"/> Hiatal hernia <input type="checkbox"/> Ulcers <input type="checkbox"/> Colitis <input type="checkbox"/> Nausea / vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in vomit / stool <input type="checkbox"/> None of the above <input type="checkbox"/> Other _____

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:

GASTROINTESTINAL (CONT.)	NEUROLOGICAL (CONT.)	ENDOCRINE and METABOLIC
<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis <input type="checkbox"/> G-tube <input type="checkbox"/> J-tube <input type="checkbox"/> Colostomy <input type="checkbox"/> Other liver disease <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Gallbladder disease <input type="checkbox"/> Any type of intestinal disease <input type="checkbox"/> Enlarged spleen <input type="checkbox"/> Appendicitis <input type="checkbox"/> None of the above <input type="checkbox"/> Other _____	<input type="checkbox"/> Difficulty with movement <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Vagus nerve stimulator (VNS) <input type="checkbox"/> Shunt <input type="checkbox"/> Concussion <input type="checkbox"/> None of the above <input type="checkbox"/> Other _____	<input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disorder <input type="checkbox"/> Adrenal gland disorder <input type="checkbox"/> Growth hormone deficiency <input type="checkbox"/> Pituitary disorder <input type="checkbox"/> Other endocrine tumors <input type="checkbox"/> Vitamin deficiency <input type="checkbox"/> Hormone therapy <input type="checkbox"/> None of the above <input type="checkbox"/> Other _____
MUSCULOSKELETAL	SKIN, HAIR, NAILS and BREASTS	PSYCHIATRIC / BEHAVIORAL
<input type="checkbox"/> Artificial joint(s) <input type="checkbox"/> Arthritis <input type="checkbox"/> Scoliosis <input type="checkbox"/> Gout <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Fractures <input type="checkbox"/> Muscular dystrophy <input type="checkbox"/> Myasthenia gravis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Spinal Rod <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Any other muscle or bone disorder <input type="checkbox"/> None of the above <input type="checkbox"/> Other _____	<input type="checkbox"/> Rash <input type="checkbox"/> Skin cancer <input type="checkbox"/> Skin sores <input type="checkbox"/> Itching or pain in skin <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema <input type="checkbox"/> Hair loss or brittle hair <input type="checkbox"/> Ectodermal dysplasia <input type="checkbox"/> Problems with nails of hand or feet <input type="checkbox"/> Breast pain <input type="checkbox"/> Breast lumps <input type="checkbox"/> Breast discharge <input type="checkbox"/> None of the above <input type="checkbox"/> Other _____	<input type="checkbox"/> Impulsivity <input type="checkbox"/> Obsessive Compulsive Disorder (OCD) <input type="checkbox"/> Attention Deficit/Hyperactivity (AD/HD) <input type="checkbox"/> Anxiety / Panic attacks <input type="checkbox"/> Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Hallucinations <input type="checkbox"/> Self Injurious Behavior (SIB) <input type="checkbox"/> Aggressive behavior (physical or verbal) <input type="checkbox"/> Property destruction <input type="checkbox"/> None of the above <input type="checkbox"/> Other _____
IMMUNOLOGICAL	HEMATOLOGICAL and VASCULAR	USE OF IMMOBILIZATION
<input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Any autoimmune disease <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Any chronic infection <input type="checkbox"/> Cancer, tumors or growths <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> None of the above <input type="checkbox"/> Other _____	<input type="checkbox"/> Easy bleeding <input type="checkbox"/> Sickle cell anemia or trait <input type="checkbox"/> Any type of anemia <input type="checkbox"/> Any type of blood disorder <input type="checkbox"/> History of blood clots <input type="checkbox"/> Swelling in the legs <input type="checkbox"/> Lower leg pain when walking <input type="checkbox"/> None of the above <input type="checkbox"/> Other _____	<input type="checkbox"/> Use of mouth prop <input type="checkbox"/> Weighted blanket <input type="checkbox"/> Use of wrist wrap <input type="checkbox"/> Use of lap belt <input type="checkbox"/> Use of papoose <input type="checkbox"/> Oral sedation <input type="checkbox"/> In-office I.V. sedation <input type="checkbox"/> General anesthesia in operating room <input type="checkbox"/> None of the above <input type="checkbox"/> Other _____
NEUROLOGICAL	SENSORY	
<input type="checkbox"/> Headache <input type="checkbox"/> Seizures <input type="checkbox"/> Impaired coordination or balance <input type="checkbox"/> Weakness or paralysis <input type="checkbox"/> Spastic muscles <input type="checkbox"/> Stroke	<input type="checkbox"/> Seeks out sensations or stimulus (specify: examples include mouthing objects, seeking weights or pressure, seeking music, seeking other stimulus) <input type="checkbox"/> Bothered or distracted by sensations that do not bother others (please specify and give examples e.g. smells, sounds, lights, sensations, etc.) <input type="checkbox"/> Tolerates or seeks out stimuli that are noxious, dangerous, or perceived as harmful by others (specify) <input type="checkbox"/> Unusual responses to stimuli (specify: for example gags easily, fearful of stairs, other)	

Please describe any items checked above:

**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.**

		FOR OFFICIAL USE ONLY
_____ Signature of person completing form and relationship	_____ Date	_____ Medical Director Signature and Date
_____ Signature of Patient's Legal Representative	_____ Date	_____ Dental Director Signature and Date





COMMONWEALTH OF KENTUCKY  
 CABINET FOR HEALTH AND FAMILY SERVICES  
**OUTPATIENT OR RESPONSIBLE PARTY  
 FINANCIAL RECORD**

**If patient has Medicaid coverage, please continue on to page number two in lieu of filling out the below, 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)

<input type="checkbox"/>	Self (outpatient) Salary Income	_____	Current or Last Employer:	_____
<input type="checkbox"/>	Other Responsible Person	_____	Other Responsible Person Name:	_____
<input type="checkbox"/>	Social Security	_____		
<input type="checkbox"/>	Veteran's Adm.	_____		
<input type="checkbox"/>	Company Pension	_____		
<input type="checkbox"/>	Other (describe)	_____		
	<b>Total Income</b>	<u>_____</u>		

(NOTE: Gross Income Which will continue during treatment and after discharge of patient)

2. Financial Assets Amount Remarks

<b>Savings Account</b> .....	\$ _____	
Bank _____		
Value of Stocks Bonds .....	_____	
<b>Checking Account Balance</b> .....	_____	
Bank _____		
Other _____		
<b>Asset Total</b>	<u>\$ _____</u>	

3. Social Security and Income Taxes

Social Security Taxes	_____	
State Income Taxes	_____	
Federal Income Taxes	_____	
<b>Total Taxes Deduction</b>	<u>_____</u>	^ Taxes may be estimated to total 25 % of total income in lieu of actual tax values withheld or paid.

4. Unpaid Medical/Dental Bills

	<u>Names</u>	<u>Unpaid Bills</u>	<u>Month/Year Incurred</u>
State Facilities	_____	\$ _____	_____
Hospitals	_____	_____	_____
Clinics	_____	_____	_____
Physicians	_____	_____	_____
Dentists	_____	_____	_____
<b>Total Medical Bills Deduction</b>		<u>\$ _____</u>	

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	\$ _____

**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	Med. Assistance No.	Other (specify)	Social Security No. of Policy Holder(s)	
	<input type="checkbox"/> <input type="checkbox"/>			----- -----	
(check applicable boxes)					

Based upon the above financial data, 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**

Note: Page one of the Financial Record form is to be prepared to determine an outpatient patient'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 applied to the cost of services before determining any outpatient client Ability to Pay amount.

## Authorization for Use and/or Disclosure of Patient Health Information

You may authorize, below, specific individuals to whom PHI (Protected Health Information) may be released. If necessary, please list other recipients on the back of this form.

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

I hereby authorize the use and disclosure of the patient information as described in the *Notice of Privacy Practices* to the below named person/s. 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. I understand that in order for Lee Specialty Clinic to provide continuity and quality care, they may need to discuss the patient's visit summary or aftercare guidance to the person who has accompanied the patient. I understand that PHI may be released to the party present at the clinic with the patient.

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

Type of Information to be released:

Type of Information to be released:

Diagnosis      Plan of Care  
Payment      Other:

Diagnosis      Plan of Care  
Payment      Other:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

Type of Information to be released:

Type of Information to be released:

Diagnosis      Plan of Care  
Payment      Other:

Diagnosis      Plan of Care  
Payment      Other:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

Type of Information to be released:

Type of Information to be released:

Diagnosis       Plan of Care  
 Payment       Other:

Diagnosis       Plan of Care  
 Payment       Other:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

Type of Information to be released:

Type of Information to be released:

Diagnosis       Plan of Care  
 Payment       Other:

Diagnosis       Plan of Care  
 Payment       Other:

\_\_\_\_\_  
Signature of Patient's Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient's Legal Representative (Please Print)

\_\_\_\_\_  
Date



COMMONWEALTH 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 Lee Specialty Clinic, 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 Relationship to Patient Date  
 Responsible Party(s)

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

## TELEMEDICINE INFORMED CONSENT FORM

### Patient Information

Patient Name:

DOB:

Site Where Patient is Seen for Telemedicine (provide city and state):

Provider Location:  
Louisville, KY 40216

### Introduction

You are going to have a clinical encounter using telemedicine technology (videoconferencing and/or telephone). You will be able to see and/or hear the provider and they will be able to see and/or hear you, just as if you were in the same room. Since 1994, the technology has connected tens of thousands of patients and providers in Kentucky. The information may be used for diagnosis, treatment, therapy, follow-up and/or education.

#### Expected Benefits:

- Improved access to care by enabling a patient to remain within the facility and obtain services from providers at distant sites.
- Patient remains closer to home where local healthcare providers can maintain continuity of care.
- Reduced need to travel for the patient or provider.

#### The Process:

You will be introduced to the provider and anyone else who is in the room with the provider. You may ask questions of the provider, anyone with the provider, or any telemedicine staff in the room with you. If you are not comfortable seeing or hearing a provider using videoconference or telephone technology, you may decline the use of the technology and schedule a traditional face-to-face encounter at any time. Safety measures are being used to ensure that the videoconference is secure, and no part of the encounter will be recorded without your written consent.

#### Possible Risks:

There are potential risks associated with the use of telemedicine which include, but may not be limited to:

- A provider may determine that the telemedicine encounter is not yielding sufficient information to make an appropriate clinical decision, and this may require an in-person visit.
- Technology problems may delay medical, psychological, psychiatric, behavioral, dental or therapeutic evaluation and treatment for today's encounter.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information. You will be promptly notified if we become aware of any security issues that arise.

#### By Signing this Form, I understand the following:

1. I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
2. I understand that if the provider believes I would be better served by a traditional face-to-face encounter, the provider may at any time stop the telemedicine visit and schedule a face-to-face visit. I also understand that technology problems may necessitate an in-person visit with the provider.
3. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
4. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine.
5. I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

#### Patient Consent to the Use of Telemedicine:

I have read and understand the information provided above regarding telemedicine, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my care. I also consent to photographs of the video encounter being taken and stored in my patient file.

I hereby authorize Lee Specialty Clinic to use telemedicine in the course of my diagnosis and treatment.

\_\_\_\_\_  
Signature of Patient (or authorized person) If authorized signer, relationship to patient

\_\_\_\_\_  
Date



4501 Louise Underwood Way, Louisville, KY 40216

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

Patient Name: \_\_\_\_\_

**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, HIV/AIDS 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.

**Guardian Notification.** I understand that, from time to time, Lee Specialty Clinic clinicians may want to contact me to obtain permission to either discontinue a current psychotropic medication, pain medication or other controlled medication, or to prescribe a new psychotropic medication, pain medication or other controlled medication. If the Lee Specialty Clinic clinician or staff person is unable to contact me, I give my permission for the clinician to either discontinue or prescribe the psychotropic medication, pain medication or other controlled medication as they deem appropriate until such time as I can be reached.

**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 video recordings of the above-named patient. I understand that these images will be used solely for purposes of planning and providing clinical care, maintaining clinical records, or in consultation with other clinicians involved in the patient's care. I understand that these images will not be used for educational or promotional purposes.

**The Lee Specialty Clinic is a University-Affiliated Teaching Clinic**

I understand that the Lee Specialty Clinic serves as a training site for medical students, medical residents, dental students, dental residents, dental hygiene students and other allied health care clinicians-in-training from various local educational facilities. And, I understand and consent that, from time to time, such persons will render care to the above-named patient, and that such care will be supervised by the appropriate attending physician, dentist, hygienist or therapist in that respective discipline.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

## NOTICE OF PRIVACY PRACTICES

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### **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 (Psychotherapy notes do not include any information about medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, or results of clinical tests; nor do they include summaries of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. Those items are part of your medical records.), 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.

I affirm that I have received and read the Notice of Privacy Practices

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

Our Privacy Officer: Lisa Pillow, Clinic Administrator P 502 368-2348 F 502 368-2340

**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, they, as the professional charged with that patient's well being, *must* live up to their 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: (Please check below)

- Gentle hand holding / re-directing of hand movements
- Mouth prop to limit mouth movement
- Wrist wrap to limit upper limb movement
- Papoose wrap to limit body movement
- IVs- referral to operating room for general anesthesia

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.

**I affirm that I have received and read the Medical Immobilization consent information and consent to medical immobilization as clinically suggested for the safety of the patient.**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date



## Flu Consent

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

1. Is the person to be vaccinated sick today or had a fever of greater than 100.4°F in the last 24 hours?  
 Y  N
2. Does the person to be vaccinated have an allergy to latex, mercury, thimerosal, gelatin, chicken eggs/feathers, or other vaccine components?  Y  N
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?  Y  N
4. Has the person to be vaccinated ever had Guillain-Barre Syndrome or any other neurological diseases?  
 Y  N

I have been given a copy and have read or have had explained to me the U.S. Public Health Service important information statement about influenza vaccine dated 8/6/2021. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the risks and benefits of the vaccine and agree to receive the vaccination.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Printed Name: \_\_\_\_\_

*If any above questions are answered "yes", must have provider approval and documentation*

### Internal Use Only

Vaccine Manufacturer: GSK

NDC#: 19515-0808-52 Exp: \_\_\_\_\_

Vaccine Type:  Flulaval (egg-based)

Administered by: \_\_\_\_\_

Date: \_\_\_\_\_

Administration Site:  LD  RD  LT  RT

# Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many vaccine information statements are available in Spanish and other languages. See [www.immunize.org/vis](http://www.immunize.org/vis)

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite [www.immunize.org/vis](http://www.immunize.org/vis)

## 1. Why get vaccinated?

Influenza vaccine can prevent **influenza (flu)**.

**Flu** is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people 65 years and older, pregnant people, and people with certain health conditions or a weakened immune system are at greatest risk of flu complications.

Pneumonia, bronchitis, sinus infections, and ear infections are examples of flu-related complications. If you have a medical condition, such as heart disease, cancer, or diabetes, flu can make it worse.

Flu can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults.

In an average year, **thousands of people in the United States die from flu**, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

## 2. Influenza vaccines

CDC recommends everyone 6 months and older get vaccinated every flu season. **Children 6 months through 8 years of age** may need 2 doses during a single flu season. **Everyone else** needs only 1 dose each flu season.

It takes about 2 weeks for protection to develop after vaccination.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against the influenza viruses believed to be likely to cause disease in the upcoming flu season.

Even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Influenza vaccine **does not cause flu**.

Influenza vaccine may be given at the same time as other vaccines.

## 3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of influenza vaccine**, or has any **severe, life-threatening allergies**
- Has ever had **Guillain-Barré Syndrome** (also called "GBS")

In some cases, your health care provider may decide to postpone influenza vaccination until a future visit.

Influenza vaccine can be administered at any time during pregnancy. People who are or will be pregnant during influenza season should receive inactivated influenza vaccine.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting influenza vaccine.

Your health care provider can give you more information.



**U.S. Department of Health and Human Services**  
Centers for Disease Control and Prevention

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## 4. Risks of a vaccine reaction

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- Soreness, redness, and swelling where the shot is given, fever, muscle aches, and headache can happen after influenza vaccination.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

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## 5. What if there is a serious problem?

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An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at [www.vaers.hhs.gov](http://www.vaers.hhs.gov) or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

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## 6. The National Vaccine Injury Compensation Program

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The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at [www.hrsa.gov/vaccinecompensation](http://www.hrsa.gov/vaccinecompensation) or call **1-800-338-2382** to learn about the program and about filing a claim.

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## 7. How can I learn more?

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- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at [www.fda.gov/vaccines-blood-biologics/vaccines](http://www.fda.gov/vaccines-blood-biologics/vaccines).
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (1-800-CDC-INFO) or
  - Visit CDC's website at [www.cdc.gov/flu](http://www.cdc.gov/flu).



## **Notice Informing Individuals About Nondiscrimination and Accessibility Requirements and Sample Nondiscrimination Statement:**

### **Discrimination is Against the Law**

Lee Specialty Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. Lee Specialty Clinic does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Lee Specialty Clinic

- Provides people with disabilities with reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our front desk for assistance in ensuring that your office visit includes the necessary accommodation.

If you believe that Lee Specialty Clinic has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex,

you can file a grievance with: Lisa Pillow, [lisapillow@admed.us](mailto:lisapillow@admed.us), or 4501 Louise Underwood Way, Louisville, KY 40216 or 502 368 2348. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Lisa Pillow is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

This notice is available at Lee Specialty Clinic's website: [Leespecialtyclinic.com](http://Leespecialtyclinic.com)

Language assistance services are available free of charge

- Los servicios de asistencia lingüística están disponibles de forma gratuita.
- الترجمة المجانية المتاحة
- 免费提供语言协助服务
- Sprachassistenzen sind kostenlos zur Verfügung
- Dịch vụ hỗ trợ ngôn ngữ được cung cấp miễn phí
- Услуге језичке помоћи доступне су бесплатно.
- Usluge jezičke pomoći dostupne su besplatno.
- 無料翻訳が可能です
- Les services d'assistance linguistique sont disponibles gratuitement.
- 언어 지원 서비스는 무료로 제공됩니다.

Language assistance services are available free of charge

- Available ang mga serbisyo ng tulong sa wika nang walang bayad.
- Adeegyada kaalmada luqadda waxaa lagu heli karaa lacag la'aan
- Huduma za usaidizi wa lugha zinapatikana bila malipo
- Taalondersteuningsdiensten zijn gratis beschikbaar.
- भाषा सहायता सेवाहरू निःशुल्क उपलब्ध छन्।
- Услуги языковой поддержки предоставляются бесплатно.