There is Help Available to Pay for your Health Care:

The Community Health Net's Sliding Fee Discount Program

Community Health Net provides comprehensive and high-quality primary care services to people in need, regardless of their ability to pay. At Community Health Net you will NOT be turned away even if you don't have health insurance. Our brochure and enclosed application explain our Sliding Fee Discount Program for which you may qualify.

What is the Sliding Fee Discount Program?

It is a program that may offer you a discount on your medical bill depending on your income and family size.

What do I need to know about the Sliding Fee Discount Program?

- The program sets a discount on what you pay based on the size of your family and how much money your family makes in a year.
- You can apply for a discount even if you have insurance.
- Each health center sets its own fees and discounts.

How does the Sliding Fee Scale Discount Program Work?

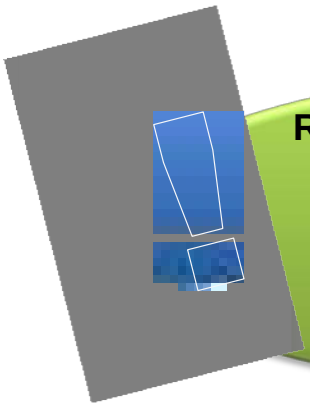
The program is designed to allow people to pay for health care services based on their ability to pay. Therefore, people making less money will pay less than people making more money.

What will I pay if I qualify for the Program?

How much you might pay will depend on your insurance, and your family income and size. Sliding fee calculations are determined by using Federal tax forms, W-2's, pay stubs, unemployment benefits, Social Security benefits. If you don't have any of those documents we will NOT turn you away; we may ask you to sign a temporary self-declaration to give you time to bring the needed documents.

How do I apply for the Program?

Please let our staff know that you are interested in applying for the Sliding Fee Discount Program.



Remember...

We at Community Health Net want to make sure that you receive the health care that you need. We will work with you to find a solution to pay for your health care services, depending on your circumstances.

PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name: Last, First, MI		Preferred Name:
Date of Birth:	Sex: □ Male □ Female	SSN:
Marital Status: □ Divorced □ Married □ Single □ Separated □ Widow □ Child		Email:
Address: (Street Name, Apt #)	City, State	Zip
Home Phone: ( )	Cell or Message Phone: ( )	Other Phone Number: ( )

PARENT / GUARDIAN INFORMATION FOR CHILD ONLY

(If you are under the age of 26 and covered by Parent's Insurance, Information is needed)

Fathers Name:	Phone Number: ( )	Email:
Fathers DOB:	Fathers SSN:	
Fathers Address: (Street Name, Apt#)	City, State, Zip	Fathers Insurance Name:
Fathers Employer:	Fathers Employer Address:	City, State, Zip Code:
Fathers Employer Phone Number: ( )		

Mothers Name:	Phone Number:	Email:
Mothers DOB:	Mothers SSN:	
Mothers Address: (Street name, Apt #)	City, State, Zip Code	Mothers Insurance Name:
Mothers Employer:	Mothers Employer Address:	City, State, Zip Code:
Mothers Employer Phone Number: ( )		

PATIENT EMPLOYMENT

(Parent employment Information Above)

Are you employed? □ Yes □ No □ FT Student □ PT Student	If employed, List Employer Name:		
Employer Address: (Street Name, Apt #)	City:	State:	Zip Code:

SPOUSE EMPLOYMENT

(If you are under their insurance plan)

Spouse's Employer Name:			
Employers Address: (Street Name, Apt/Suite #)	City	State:	Zip Code:

EMERGENCY CONTACT

Name:	Phone Number: ( )	Relationship:

Address: (Street Name, Apt/Suite #)	City:	State:	Zip Code:

PATIENT INSURANCE

Insurance Name:	Policy Number:	Group #
Policy Holder Name:	Policy Holder Birthdate:	Policy Holder SSN:

PERSONAL INFORMATION

Are you a Veteran? □ Yes □ No	Homeless: □ Yes □ No If yes, what is your situation: □ Shelter □ Transitional □ Doubling Up □ Streets □ Other

Family Size: _____ Family Income: $_____ □ Weekly □ Monthly □ Annually

Do you require Interpretation? □ Yes □ No	If yes, what language do you speak?	Interpretation Agency Name and Phone Number

Race: □ White/Caucasian □ Black/African American □ Other	Ethnicity: □ Hispanic □ Non-Hispanic

CONSENT FOR SERVICES

Authorization for care and assignment: I hereby authorize Community Health Net to obtain history, perform physical examination, administer treatment and perform clinical procedures as may be necessary for myself or minor/child and to furnish information for claim processing with fee assigned to Community Health Net.

I give the following persons (in addition to myself) my consent/permission to obtain treatment for my minor child at Community Health Net. This permission enables Community Health Net to obtain a history, examine the child, administer treatment and perform clinical procedures when the child is brought in for illness, routine health check-ups and immunizations unless indicated .

Must be 18 years or older to bring No immunizations

Mother/ Legal Guardian: _____ Relationship to Patient: _____Phone: _____ □

Father/Legal Guardian: _____Relationship to Patient: _____ Phone: _____ □

Name: _____Relationship to Patient: _____ Phone: _____ □

Name: _____Relationship to Patient: _____ Phone: _____ □

Name: _____ Relationship to Patient: _____ Phone: _____ □

X _____ Date: _____ Relationship to Patient: _____

Signature of Patient, or Parent/Legal Guardian

COMMUNITY Health Net
Everyday people. Extraordinary care.

PATIENT BILL OF RIGHTS

"As a patient of Community Health Net, you have the right to receive exceptional healthcare, regardless."

- The patient has the right to receive clear information concerning diagnosis, treatment, outcomes, and prognosis of condition. The patient has the right to discuss medical information with their provider in such a way that the patient can understand and comprehend to the best of their ability.

- The patient has the right to receive details about possible treatment or procedures in order to make a well thought out and informed decision in their healthcare.

- The patient has a right to be given the alternative immediate and long term medical/dental impact of treatment choices that are known and available to date as part of their treatment plan along with being informed of complications.

- The patient has the right to actively participate in the plan of care prior to and during the course of treatment. The patient has the right to refuse a recommended treatment plan of care to the extent permitted by law. If the patient refuses care, the patient will be asked to document their refusal in writing by completing the appropriate forms. When a patient refuses care, they have the right to be informed of the medical/dental consequences of this action.

- The patient has the right to visually identify Community Health Net healthcare providers and support staff members that are involved in the delivery of healthcare services by wearing a photographic name badge.

- The patient has a right to receive respect and kindness by licensed and qualified personnel.

- The patient is encouraged to have a current advance directive, living will, or healthcare power of attorney on file concerning treatment and designation of a surrogate/alternative healthcare decision maker in times of emergency. Community Health Net is required to advise patients of their rights under state law and to assist patients as they make informed healthy decisions. Documentation of such directive is to be included in the patients chart.

- The patient has the right to privacy. Case discussion, consultation, examination and treatment are to be conducted in a manner to protect each patient's privacy and each patient's dignity. Release of medical/dental records will only occur with the patient's written consent, as permitted by law, or third-party contractual arrangements. A patient has the right to visually examine the contents within their medical/dental chart under the presence of a provider or designated staff member of Community Health Net except for when a review of the information could be potentially harmful to the overall health and welfare of the patient. If copies of the chart are needed, the patient must complete a request to release records in writing by completing the correct forms.

- The patient has the right to expect continuity of care. The patient has the right to be informed by their provider when additional healthcare decisions are needed such as: hospital care, in-home support services, nursing home, and relative care option when present situations are no longer effective and appropriate.

- The patient has the right to seek advice or a second opinion from another medical provider at the patient's own expense.

- The patient has the right to clearly understand the pain scale and how pain is treated by your provider relative to your diagnosis.

- The patient as the right to request information regarding fees and charges assessed related to services rendered regardless of their ability to pay for such services. The patient has a right to receive a detailed explanation of their bill. If a patient does not have active insurance coverage, they are encouraged to apply for the "Sliding Fee Scale" that adjusts fees based on family size and income.

- The patient who does not speak English as the right to access translation services whenever possible.

- The patient has the right to have their questions and concerns addressed.

If you have a concern that you feel needs further attention, please contact: Community Health Net
Attn: Administration
1202 State Street, Erie, PA 16501
(814) 454-4530

You may also file a complaint with the Joint Commission on Accreditation of Healthcare Organizations by emailing patientsafetyreport@jointcommission.org or faxing your concern to the Office of Quality and Patient Safety at (603) 792-5636 or mailing your correspondence to: Office of Quality and Patient Safety
Joint Commission
One Renaissance Boulevard Oakbrook Terrance, IL 60181

COMMUNITY Health Net
Everyday people. Extraordinary care.

PATIENT RESPONSIBLITIES

"Welcome to Community Health Net. We are glad to be your partner in health."

As a patient of Community Health Net FQHC, it is your responsibility:

- To actively participate in your health by being responsible for daily choices that impact your overall health.
- To give your healthcare provider truthful and accurate facts regarding your health situation including: present concerns information regarding past health issues, recent emergency room visits, recent hospitalizations, and information regarding medications both prescription drugs and over-the-counter items such as herbs, vitamins, holistic treatments, and non-prescribed drugs.
- To provide updates to any changes in: your medical condition, address, phone number, insurance coverage, name change, etc. from the last office visit to the present office visit.
- To be compliant by following instructions as ordered by your healthcare provider concerning: proper use of medications, required return office visits, and other essential steps that are vital to your treatment plan. If a problem arises that prohibits the orders to be followed as described, it is your responsibility to notify your healthcare provider immediately.
- To ask questions as needed to ensure a clear understanding of your health condition.
- To show respect to all Community Health Net providers and staff in a kind and courteous manner. To avoid swearing and outward representation of verbal and physical anger. The entire staff is here to help you, not to create barriers to your healthcare.
- To be considerate of privacy and confidentiality of other patients in the waiting room and exam rooms.
- To be respectful and considerate of other patients by limiting excessive noise, keeping children under control, and respecting other patient's personal property and space.
- To keep appointments as set forth and to notify Community Health Net 24 hours in advance if appointments cannot be kept. We would be happy to work with you to reschedule your appointment to better accommodate your needs.
- To be responsible for all payments due in a timely manner for all services rendered by Community Health Net. If this is not possible, contact the Billing Department to make alternative financial arrangements.

_____ _____

Name Date

_____ _____

Witness Date

ASSIGNMENT OF INSURANCE BENEFITS

Our office requests that you read your insurance policy to be fully aware of any limitations of the benefits provided. You should be aware that the insurance agreement is between you and the insurance company. We will gladly help you, but it is your responsibility to know the limitations of your policy. By signing below, you will agree that any insurance benefits which apply to the services furnished by Community Health Net are to be paid directly to Community Health Net. Any charges incurred beyond the reimbursement of your policy, will be your financial responsibility.

I have read the above and I understand my financial obligation. I agree to be legally bound by the foregoing and hereby authorize payment of medical/dental benefits to Community Health Net for services performed.

Signature: _____ Date: _____

Revised 11/08

Privacy Practices Notice Acknowledgment

I understand that Community Health Net FQHC is required by the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") to maintain the privacy of my protected health information and provide me this notice of their legal responsibilities and privacy practices regarding health information about me.

My signature below attests that I have been provided with Community Health Net's HIPAA Privacy Practices Notice that complies with their legal responsibility. In addition, my signature below attests that I have read, understood and agree with this notice that describes how information about me may be used and disclosed and how I can have access to this information.

I understand that Community Health Net will not retaliate against me for filing a complaint, nor will filing a complaint have any affect or bearing on the quality of care I receive.

Patient's Name _____

Relationship to Patient: _____

Signature _____

Date _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgment of this form but was unable to do so as documented below.

Date	Signature:	Reason:

Rev. 07/08

PATIENT COPY

Privacy Practice Notice

This notice describes how information about you may be used, disclosed and how you can get access to this information. Please read it carefully.

At Community Health Net, we will treat and use protected health information about you with care. This notice of protected health information practices describes the information we collect, and how we use or disclose that information. This notice is effective 4-14-2003, and applies to all protected health information.

Each time you visit Community Health Net a record of your visit is made. Typically this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment.

This information, serves as a:

- Basis for planning your care and treatment
- Means of communication among the health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third party payer can verify services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this state and the nation
- A source for our planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when allowing disclosure to others.

Your Health Information rights:
Although your health records are the physical property of Community Health Net, the information belongs to you.
You have the right to:

- Obtain a copy of this notice of information practices upon request
- Inspect and obtain a copy of your health record
- Amend your health record
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities:
Community Health Net is required to maintain the privacy of your health information, provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, and to abide by the terms of this notice. We will notify you if we are unable to agree to a requested restriction or amendments; and accommodate reasonable requests you may have to communicate health information by alternative means or alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization, as allowable by law.

If you have questions and would like additional information, you may contact our office.

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the Office for Civil Rights, we will not retaliate against you for filing a complaint, nor will filing a complaint have any affect or bearing on the quality of care you receive.

To file a complaint or for more information about the compliance process and HIPAA, please contact	
Community Health Net Tyler Monin 1202 State Street Erie, PA 16501 (814) 454-4530	U.S. Department of Health and Human Services Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 (202) 619-0257 Toll Free: 1-877-696-6775

PATIENT COPY