Juniper Health Inc. Patient Information

Thank you for choosing our office. In order to serve you properly, we request you provide the following information:
Photo ID and ALL Insurance and Prescription Cards

Patient Name:_______________ SSN:_______________ Birthdate:___________ Gender:_______

Mailing Address:_______________ City_______________ State______ Zip__________

Home Phone:_______________ Cell Phone:_______________ Other Phone:_______________

Email Address: _______________

Legal Guardian Name:_______________ Legal Guardian SSN:_______________

Emergency Contact (Please list the nearest friend or relative NOT living with you)

Name of person to contact in case of emergency: _______________ Phone Number: _______________

Responsible Party (if different from patient)
Name of person responsible for this account:_______________ Relationship to patient:_______________

Address:_______________ SSN:_______________ Date of Birth:_______________

Employment
Employer: _______________ Work Phone:_______________

Business Address: _______________ City:_______________ State:________ Zip:_______________

Income (to determine eligibility for our DISCOUNT program, even if you have insurance)
Household Size:_______________ **Household Yearly Income Amount:**_______________

Check Appropriate Box. We are REQUIRED by our federal funding agency to ask these questions.

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Are you a student? ☐Full-Time ☐Part-Time ☐Not a Student

Race: ☐White ☐Hispanic ☐Black/African American ☐Asian ☐Other________

Ethnicity: ☐Non-Hispanic or Latino ☐Hispanic or Latino

Language: ☐English ☐Spanish ☐French ☐Creole ☐Other

Are you a Veteran? ☐Yes ☐No
Are you a migrant or seasonal laborer? ☐Not Migrant or Seasonal ☐Migrant ☐Seasonal
Are you homeless? ☐Non-homeless ☐Homeless Shelter ☐Transitional ☐Doubling Up ☐Street
Are you a resident of public housing? ☐Yes ☐No

Gender: ☐ Male ☐Female ☐Transgender Male/Female-to-Male ☐Transgender Female/Male-to-Female
☐Gender Queer ☐Other ☐Choose not to disclose

Sexual Orientation: ☐Straight or heterosexual ☐Lesbian, gay or homosexual ☐Bisexual ☐Something else
☐Don't know ☐Choose not to disclose

_______________ _______________
Signature of Patient/Legal Guardian Date

JHI

PATIENT REGISTRATION INFORMATION

Juniper Health, Inc.

CONSENT TO TREATMENT

I/we voluntary authorize the rendering of such care, including diagnostic procedures and medical treatment, by authorized agents and employees of Juniper Health, Inc. (hereafter referred to as the Clinic), the medical staff, or their designees, as may in their profession al judgment be deemed necessary or beneficial, and may include testing for HIV (the virus that causes AIDS) and other blood borne diseases. I/we acknowledge that no guarantees have been made as to the effect of such examination of treatment on my condition or the condition of the person for whom guarantees have been made as to the effect of such examination or treatment on my condition or the condition of the person for whom I am duly authorized to sign. I/we understand that I/we have the right to make decisions concerning my health care or the health care of the person for whom I am duly authorized to make such decisions, including the right to refuse medical and surgical procedures.

ADVANCE DIRECTIVES

☐ I have formulated Advance Directives (living will, health care surrogate declaration, durable power of attorney, DNR order) and request that these directives govern my course of care, in as much as is possible under state or federal law. I understand that it is my responsibility to provide the Clinic with a copy of my Advance Directive and that those directives will not govern my course of car e until they have been filed in my medical record.

☐ Advance Directives attached ☐ Advance Directives not attached

☐ I have not formulated Advance Directives (living will, health care surrogate declaration, durable power of attorney, DNR order), but I understand that it is my right to make decisions regarding my course of treatment, including the executing of Advance Directives.

ASSIGNMENT OF BENEFITS

I hereby assign to Juniper Health, Inc. any insurance or other third-party benefits available for health care services provided to me. I understand that Juniper Health, Inc. has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Juniper Health, Inc., I agree to forward to Juniper Health, Inc., all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

INSURANCE COVERAGE WAIVER

I understand that my eligibility for coverage by (________________________________) cannot be confirmed at this time. I wish to receive medical service from____. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

PATIENT CENTERED MEDICAL HOME MODEL – SELECTION OF PERSONAL CLINICIAN

As a new patient, the first step in managing your own care is to choose a team of care providers that you wish to provide your care. Each care team is led by your own personal clinician. Please select your personal clinician from the list below.

Juniper Health Breathitt County Clinicians:

☐ Derrick Hamilton, DO	☐ Allison Manning, APRN	☐ Kimberli Plumb-Moore, MD	☐ E. Allan Mendoza, MD
☐ Brittany Fugate, DO	☐ Beverly Ellis, APRN	☐ Amanda Blackburn, PA-C	☐ Tami Osborne, APRN
☐ Jennifer Dickey, APRN	☐ Kelsea Combs, PA-C	☐ Heather Banks, APRN	☐ George Chapman, DO
☐ Scotty Combs, APRN	☐ Ben West, PA-C		

Juniper Health Lee County Clinicians:

☐ Jessica Botner-Wilson, PA-C ☐ Brittany Fugate, DO DO ☐ Tami Osborne, APRN ☐ Kelsea Combs, PA-C

Juniper Health Wolfe County Clinicians:

☐ Alissa Bell, APRN ☐ Brittany Fugate, DO ☐ Tami Osborne, APRN ☐ Jennifer Dickey, APRN

Juniper Health Morgan County Clinicians:

☐Sandra McClure, APRN ☐ George Chapman, DO ☐ Tami Osborne, APRN

Juniper Health Elliott County Clinicians:

☐ Tami Osborne, APRN ☐ Wendy Withrow, APRN

Dental Only:

I do not see a Juniper Health medical provider. My dentist is: ☐Lisa Hall, DMD ☐Leigh Ann Gunnell, DMD ☐Lin Peng, DMD ☐Roger Worthington, DMD

PATIENT SIGNATURE CONFIRMATION

I hereby confirm that I have read the following Juniper Health Policies and acknowledge that these Policies are posted in the clinic lobby, may be made available upon request and may be accessed through the Juniper Health website (www.juniperhealth.org):

- Patient Rights and Responsibilities
- Insurance Waiver Policy
- Assignment of Benefits Policy
- Advance Directives
- Notice of Privacy Practices
- Patient Grievance Procedure

Signature of Patient or Legal Guardian: ____

Date: _________________________

If patient is unable to sign, secure consent of Next of Kin or Legal Agent and indicate reason by checking the appropriate box:

☐ Minor ☐ Disoriented ☐ Medically Unstable ☐ Incompetent

Juniper Health

AUTHORIZATION FOR TREATMENT/RELEASE OF MEDICAL INFORMATION

Patients 18 years of age and older please complete this section:

I,____give Juniper Health permission to release medical information and/or treatment information to the following person(s):

Name	Date of Birth	Relationship

Patient Signature:____Date:__________________

For patients UNDER 18 years of age please complete this section:

I, _________________________________, parent/legal guardian of ______________________________authorize Juniper Health, Inc., to provide medical services to said child. I give permission for the following adults, acting as my agent, to bring my child for treatment. I authorize Juniper Health, Inc., to release my child's medical information concerning the treatment that my child received on that date to the person who brings my child for treatment.
I understand that this person may be asked to present Picture ID when they bring my child for treatment. This authorization expires one calendar year from the date of the execution.

Name	Date of Birth	Relationship

For patients UNDER 18 years of age please sign this section:

Signed ____ , Parent/Legal Guardian
Date: ____
Witness____, Juniper Health Employee
**If not signed in the presence of a Juniper health, Inc., employee, this signature must be notarized.

JUNIPER HEALTH, INC.

DENTAL MEDICAL HISTORY

Patient Name:______________________________________ Birth Date:______________________ Date:_______________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○Yes ○No If yes, Physician's name: ____

Have you ever been hospitalized or had a major operation? ○Yes ○No If yes, ____

Have you ever had a serious head or neck injury? ○Yes ○No If yes____

Are you taking any medications, pills, or drugs? ○Yes ○No If yes,____

____

Do you take or have you taken, Phen-Fen or Redux? ○Yes ○No If yes____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonate? ○Yes ○No If yes____

Are you on a special diet? ○Yes ○No

Do you use tobacco? ○Yes ○No

Do you use controlled substances? ○Yes ○No If yes____

Women: Are you……… □Pregnant/Trying to get pregnant? □Nursing? □Taking oral contraceptive?

Are you allergic to any of the following?

□Aspirin □Penicillin □Codeine □Acrylic

□Metal □Latex □Sulfa Drugs □Local Anesthetics

□Other □Yes □No If yes____

Do you have or have you had, any of the following?

AIDS/HIV Positive	□Yes	□No	Cortisone Medicine	□Yes	□No	Hemophilia	□Yes	□No	Radiation Treatments	□Yes	□No
Alzheimer's Disease	□Yes	□No	Diabetes	□Yes	□No	Hepatitis A	□Yes	□No	Recent Weight Loss	□Yes	□No
Anaphylaxis	□Yes	□No	Drug Addiction	□Yes	□No	Hepatitis B or C	□Yes	□No	Renal Dialysis	□Yes	□No
Anemia	□Yes	□No	Easily Winded	□Yes	□No	Herpes	□Yes	□No	Rheumatic Fever	□Yes	□No
Angina	□Yes	□No	Emphysema	□Yes	□No	High Blood Pressure	□Yes	□No	Rheumatism	□Yes	□No
Arthritis/Gout	□Yes	□No	Epilepsy or Seizures	□Yes	□No	High Cholesterol	□Yes	□No	Scarlet Fever	□Yes	□No
Artificial Heart Valve	□Yes	□No	Excessive Bleeding	□Yes	□No	Hypoglycemia	□Yes	□No	Sickle Cell Disease	□Yes	□No
Artificial Joint	□Yes	□No	Excessive Thirst	□Yes	□No	Hives or Rash	□Yes	□No	Shingles	□Yes	□No
Asthma	□Yes	□No	Fainting Spells/Dizziness	□Yes	□No	Irregular Heartbeat	□Yes	□No	Sinus Trouble	□Yes	□No
Blood Disease	□Yes	□No	Frequent Cough	□Yes	□No	Kidney Problems	□Yes	□No	Spina Bifida	□Yes	□No
Blood Transfusion	□Yes	□No	Frequent Diarrhea	□Yes	□No	Leukemia	□Yes	□No	Stomach/Intestinal Disease	□Yes	□No
Breathing Problems	□Yes	□No	Frequent Headaches	□Yes	□No	Liver Disease	□Yes	□No	Stroke	□Yes	□No
Bruise Easily	□Yes	□No	Genital Herpes	□Yes	□No	Low Blood Pressure	□Yes	□No	Swelling of Limbs	□Yes	□No
Cancer	□Yes	□No	Glaucoma	□Yes	□No	Lung Disease	□Yes	□No	Thyroid Disease	□Yes	□No
Chemotherapy	□Yes	□No	Hay Fever	□Yes	□No	Mitral Valve Prolapse	□Yes	□No	Tonsillitis	□Yes	□No
Chest Pain	□Yes	□No	Heart Attack/Pressure	□Yes	□No	Osteoporosis	□Yes	□No	Tuberculosis	□Yes	□No
Cold Sores/Fever Blisters	□Yes	□No	Heart Murmur	□Yes	□No	Pain in Jaw Joints	□Yes	□No	Tumors or Growths	□Yes	□No
Congenital Heart Disorder	□Yes	□No	Heart Pacemaker	□Yes	□No	Parathyroid Disease	□Yes	□No	Ulcers	□Yes	□No
Convulsions	□Yes	□No	Heart Trouble/Dyspnea	□Yes	□No	Psychiatric Care	□Yes	□No	Venereal Disease	□Yes	□No
Yellow Jaundice	□Yes	□No									

Have you ever had any serious illness not listed above? □Yes □No If yes____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status

____ ____

Patient/Legal Guardian Signature Date

Juniper Health

General Supervision Consent Form

First Name:_________________________ Last Name:______________________Birthdate:______________

To increase access to care, it is the policy of Juniper Health to allow a licensed dental hygienist to provide services to patients without the supervising dentist being present in the clinic if the dentist has examined the patient within the last seven (7) months per KRS.313.040.

Please read the following statements and initial each:

_______ I acknowledge that I was made aware that the supervising dentist would not be present in the clinic at the time of my appointment.

_______ I agree to be seen without the supervising dentist being present in the clinic at the time of my appointment.

Patient /Legal Guardian Signature:____ Date:______________

Relationship to Patient:____

**Witness:____

Juniper Health, Inc. NOTICE OF PRIVACY PRACTICES

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

This notice takes effect on September 23, 2013 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICALINFORMATION

The privacy of your medical information is important to us and we are committed to protecting it. As part of this commitment, we follow federal and state laws which require us to maintain your health information privacy and provide you with this notice. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to: 1. Keep your medical information private and secure. We will inform you promptly if a breach occurs that may have compromised the privacy or security of your information. 2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information. 3. Follow the terms of the current notice. 4. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time by informing us in writing.

We Have the Right to: 1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law. 2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices: Before we make an important change in our privacy practices, we will change this notice, post it in a conspicuous place in our facilities and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization, including sharing most psychotherapy notes. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

SHARED MEDICAL RECORD: We may participate in arrangements with other health care organizations or government entities, who have agreed to work with each other to facilitate access to health information that may be relevant to your care. For example, if you are admitted to a hospital on an emergency basis an d cannot provide important information about your health condition, this arrangement will allow us to make your health information available to those who need it to treat you. We store health information in an electronic health record that may be shared with other health care providers who participate in agreements with Juniper. You may contact 606-464-0151 for a list of providers who participate in the electronic health record arrangement.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

Disclosures to Business Associates: In order for us to carry out treatment, payment or health care operations, we may disclose your health information to persons or organizations who perform a service for or on our behalf that requires the use or disclosure of individually identifiable health information. Such persons or organizations are our business associates. For example, we may disclose health information to an agency that accredits health care organizations or to vendors who service our electronic health record system.

Relatives, Close Friends and Other Caregivers: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, and Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witn4ess, crime victim or missing person. We may share the medical information of an inmate or other pers on in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charge with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Worker's Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You maybe also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will provide you with one (1) free copy and additional copies will be provided at a charge of one dollar ($1.00) for each page. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions for six years prior to the date you ask.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, and we may say "no" if it would affect your care. If we do agree to your requested additional restrictions, we will abide by our agreement (except in the case of an emergency). If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless any law requires us to share that information.
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.
7. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

5. QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services Office for Civil Rights (200 Independence Avenue SW, Washington DC 20201; 1 -877-696-6775; www.hhs.gov/ocr/privacy/hipaa/complaints/.) You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

Juniper Health, Inc.
Attn: Compliance
P.O. Box 690
Beattyville, KY 41311

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

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PATIENT INFORMATION JUNIPER HEALTH, INC.

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

1. A patient has the right to considerate and respectful care, regardless of race, creed, or color.
2. A patient has the right to obtain complete current information concerning his diagnosis, treatment and prognosis. If the Medical Provider believes it medical inadvisable to give information to the patient, it must be made available to an appropriate representative of the family. The name of the Medical Provider must be available upon request.
3. A patient has the right to receive information necessary to give his informed consent prior to the start of any procedure, treatment, and to information regarding alternative procedures or treatments available.
4. A patient had the right to refuse treatment to the extent permitted under law and if he is fully informed of the medical consequences ofrefusal.
5. A patient has the right to privacy concerning his medical care program. Those not directly involved in his care must have his permission to be present during case discussions, examinations, or treatments.
6. A patient has the right to confidential treatment of all records pertaining to his care.
7. A patient has the right to reasonable response to his request for services. If referral to another doctor is recommended by the medical provider, the patient must be given full information and explanation of need for referral and any possible alternatives.
8. A patient has the right to know the relationship between his doctor and hospitals or any other health care institutions involved in his care.
9. A patient has the right to be informed of any plan to engage in any experimentation affecting his care of treatment and to refuse to participate in such projects.
10. A patient has the right to expect reasonable continuity of care, and to be informed of continuing health care requirements after treatment by the medical provider.
11. A patient has the right to examine his bill and receive an explanation of all or any changes, regardless of method of payment.
12. A patient has the right to be informed of any clinic rules or regulations that relate to his conduct as a patient.
13. The patient has the right to know what rules and regulations apply to his/her conduct as a patient including his/her right to make suggestions or file a grievance. All suggestions or grievances should be made known to the Executive Director, and a hearing to all grievances will be given by the Executive Director or his/her designee within five (5) working days of notification. Appeals to the Executive Director's determination may be made directly to the Board of the Center.
14. Patients must assume reasonable responsibility for improving their own health status. Specific responsibilities include maximizing healthy habits, openly communicating with the provider, realizing the limits of the service of medicine and being compliant with the plan of treatment for an illness.

FINANCIAL RESPONSIBILITY / GUARANTEE OF PAYMENT

1. As a courtesy, this office will submit bills to your primary insurance carrier; however, every patient has final responsibility for his/her bill. It is also the patient's responsibility to find out what his/her insurance will or will not pay.
2. It is the patient's responsibility to pursue slow payment or non-payment on the part of his/her insurance carrier by contacting the Insurance Company directly regarding the claim. We will be happy to assist you with any collections problems, however, keep in mind the bill remains the full responsibility of the patient.
3. No patient will be declined service simply because of an inability to pay for services. Patients with no third-party insurance coverage will be expected to provide appropriate information for the completion of a Sliding Scale Eligibility form. Patients qualifying for a sliding scale discount will be expected to pay an affordable flat fee at the time services are rendered.
4. There is a thirty-five dollar ($35.00) charge for a form being completed by the attending physician.
5. We are an actively participating Medicare provider.
6. There will be a twenty-five dollar ($25.00) service charge for all returned checks.
7. Self-pay bills will be mailed to all patients on a monthly basis and are due thirty (30) days from the date of the invoice. A bill becomes delinquent after ninety (90) days without payment. Should I/we fail to honor this agreement, I/we agree to pay any collection cost or attorney fees resulting from the collection of my accounts.

PATIENT GRIEVANCE PROCEDURE

It shall be the policy of Juniper Health, Inc. to receive, investigate, and respond to patient's and family's complaints regarding quality of medical care/services at the earliest possible time in the following manner.

Responsibility/Action:

1. **Patient or Family**
   a. Register verbal complaint with provider and administrator.
   b. Request written addresses of appropriate individuals or agencies to register complaint.
2. **Provider/Staff member**
   a. Complaint is resolved, and findings/outcome are documented on the Patient Complaint/Grievance Form and given to the administrator for review.
   b. Provide addresses of appropriate individuals or agencies to patient or patient representative.
   c. Provide patient with privacy to communicate, whether written or by telephone, with appropriate individual or agency, if necessary.
3. **Chief Executive Officer**
   a. Reviews Patient Complaint/Grievance Form
   b. Patient is informed of the results.
   c. Files all copies of complaints and their final disposition.

ASSIGNMENT OF BENEFITS

I hereby assign to Juniper Health, Inc. any insurance or other third-party benefits available for health care services provided to me. I understand that Juniper Health, Inc. has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Juniper Health, Inc., I agree to forward to Juniper Health, Inc., all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

INSURANCE COVERAGE WAIVER

I understand that my eligibility for coverage by (___________________________________) cannot be confirmed at this time. I wish to receive medical service from ____ _. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

ACCESS TO CARE

Juniper Health Lee County
1025 Grand Avenue
Beattyville, KY 41311
Phone: (606) 464-2401
Fax: (606) 464-3290
Office Hours:
Monday: 8:00 AM – 8:00 PM
Tuesday - Friday: 8:00 AM – 5:00 PM

Juniper Health Breathitt County
1484 Lakeside Dr.
Jackson, KY 41339
Phone: (606) 666-9950
Fax: (606) 666-9136
Office Hours:
Mon - Fri: 8:00 AM – 8:00 PM
Saturday: 8:00 AM – 5:00PM

Juniper Health Wolfe County
202 Plummer St.
Campton, KY 41301
Phone: (606) 668-7385
Fax: (606) 668-7009
Office Hours:
Mon & Wed: 8:30 AM – 8:00 PM
Tues, Thurs & Fri: 8:30 AM – 5:00 PM

Juniper Health Lee County Dental
60 Center St.
Beattyville, KY 41311
Phone: (606) 464-9262
Fax: (606) 208-8022
Office Hours:
Mon – Fri: 8:00 AM – 5:00 PM

Juniper Health Morgan County
1219 West Main St.
West Liberty, KY 41472
Phone: (606) 743-4808
Fax: (606) 743-4716
Office Hours:
Mon – Fri: 8:30 AM – 5:00 PM

Juniper Health Morgan County Dental
672 Main St.
West Liberty, KY 41472
Phone: (606) 743-3030
Fax: (606) 743-7480
Office Hours:
Mon – Fri: 8:00 AM – 5:00 PM

Juniper Health Elliott County
308 KY 7 North
Sandy Hook, KY 41171
Phone: 606-738-9785
Fax: 859-317-2148
Office Hours:
Mon – Fri: 8:30 AM – 5:00 PM

If you wish to seek non-emergency medical advice from your personal clinician during office hours, call the clinic telephone number and speak with front registration staff. Front registration staff will route your call to the appropriate care team member and you will receive a response before the end of the business day.
To seek non-emergency medical advice after office hours, call the clinic telephone number and listen to the voice recording. The telephon e number of the after-hours on-call service will be listed. Call this number to speak to the on-call service. Provide your name, the patient's name and age, your telephone number and a brief summary of your question/problem. The on-call service will contact the provider on call. The on-call provider, who has full access to your medical record, will call you at the number provided to the on-call service.
To seek emergency medical care or advice, go to the nearest ER. The ER nearest to the Breathitt County Family Health Center, the Lee County Family Medical Clinic and the Wolfe County Family Medical Center is Kentucky River Medical Center located at 540 Jett Drive, Jackson, KY.

ELECTRONIC ACCESS TO CARE: PATIENT PORTAL

Juniper Health, Inc. offers patients electronic access to care through our Patient Portal. This free service offers patients the opportunity to:

- Request an appointment
- Request prescription refills
- Complete pre-registration forms
- Receive secure messages to remind you of upcoming appointments
- Receive secure messages to inform you of available lab results
- Securely view your personal health record
- Ask a billing question
- Pay your bill online

To access the Patient Portal, go to the Juniper Health website at www.juniperhealth.org and click on the "Make an Account" link, or ask one of our front registration staff members for more information.

FINANCIAL ACCESS TO CARE: SLIDING FEE SCALE DISCOUNT PROGRAM

Juniper Health, Inc. is a Health Center Program grantee under 42 U.S.C. 254b. This status enables us to provide services to un-insured and under-insured patients regardless of the patient's ability to pay. Eligibility for the discount program is determined using household size and total household yearly income. Patients must complete an application provided by front registration or billing staff and must provide income verification. Juniper Health, Inc. accepts the following as proof of income:

- Copy of Tax Return
- Recent Paycheck Stub

- Letter from Social Security/Disability/Unemployment/Workers Compensation

For more information or to apply for the Sliding Fee Scale Discount Program, ask our front registration or billing staff.

PATIENT CENTERED MEDICAL HOME MODEL

Juniper Health, Inc. is implementing the Patient Centered Medical Home (PCMH) model to improve our care for patients. The Patient Centered Medical Home model is a health care setting that provides comprehensive, coordinated and patient-centered primary care to patients of all ages. PCMH emphasizes the partnership between a patient and his or her personal physician, and when appropriate, family members.

The hallmarks of the PCMH model include comprehensive, patient-centered and coordinated care, accessible services, quality and safety:

Comprehensive Care

The patient centered medical home is accountable for meeting the large majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. Providing comprehensive care requires a team of care providers. This team might include physicians, advanced practice nurses, physician assistants, nurses, nutritionists, social workers, educators, and care coordinators. This team links Juniper Health, Inc. and our patients to providers and services in our communities.

Patient-Centered

The patient centered medical home provides primary health care that is relationship-based with an orientation toward the whole person. Partnering with patients and their families requires understanding and respecting each patient's unique needs, culture, values, and preferences. The medical home practice actively supports patients in learning to manage and organize their own care at the level the patient chooses. Recognizing that patients and families are core members of the care team, medical home practices ensure that they are fully informed partners in establishing care plans.

Coordinated Care

The patient centered medical home coordinates care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and supports. Such coordination is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital. Medical home practices also excel at building clear and open communication among patients and families, the medical home, and members of the broader care team. To promote clear and open communication, it is imperative that patients/families provide a complete medical history and information about care obtained outside the medical home.

Accessible Services

The patient centered medical home delivers accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone access to a member of the care team, and alternative methods of communication, such as telephone and electronic care. The medical home practice is responsive to patients' preferences regarding access.

Quality and Safety

The patient centered medical home demonstrates a commitment to quality and quality improvement by ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools to guide shared decision making with patients and families, engaging in performance measurement and improvement, measuring and responding to patient experiences and patient satisfaction, and practicing population health management.

Juniper Health, Inc. believes the patient centered medical home model is the strongest avenue for the care of our patients. Through this model, working together with their health care team, patients are able to achieve their best quality of life. To learn more about this care model, visit www.ncqa.org.

ADVANCE DIRECTIVES

It is your right to make decisions about the medical care you will receive. Those who provide you with health care services are responsible for following your wishes. However, there may be times when you may not be able to decide or make your wishes known. Many people want to decide ahead of time what kinds of treatment they want to keep them alive. Advance Directives let you make your wishes for treatment known in advance. An Advance Directive is a document written before a disabling illness. The Advance Directive states your choice about treatment and may name someone to make treatment choices if you cannot. If you have an advance directive, you increase your control over your medical treatment in the future. It also helps to ensure your right to accept or refuse medical care. If you have an advance directive, it may help your family make decisions in the future because your family will know what you want and who you want to make decisions for you if you are unable to make the decisions yourself.

There are four basic types of advance directives:

1. Medical Power of Attorney - authorizes someone to make medical decisions on your behalf if you become incompetent. A Medical Power of Attorney can be a separate document or can be part of a Durable Power of Attorney. Other powers can be included in the Durable Power of Attorney authorizing someone to act on your behalf.
2. Living Will - states your wishes about the use of artificial life support to keep you alive if you are terminally ill or permanently unconscious. It also may include your wish to donate organs and tissues after your death.
3. Health Care Surrogate - you designate a person who will make health care decisions for you if you are unable to do so. This designation can be in a Power of Attorney, a Medical Power of Attorney, Living Will, and/or DNR Order.
4. DNR (Do Not Resuscitate) Order - directs that in the event of your cardiac or respiratory arrest that your wishes in the DNR Order be honored. DNR means that if your heart stops beating or if you stop breathing, no medical procedure to restart breathing or heart function will be started by emergency medical services personnel.

We must document in your medical record whether or not you have executed an advance directive. If you have one, we will need a copy. We will abide by your advance directives. Care will be provided to you regardless of whether or not you have executed an advance directive. We will honor your advance directives to the extent permitted by law, and we support your right to actively participate in making health care decisions.