Good News Clinics will verify the information you have given in your application with an outside source. If you are not a resident of Hall County or if your household income is over 150% of the Federal Poverty Level, your application will not be approved to receive medical or dental care at Good News Clinics of through Health Access. Please make sure to sign authorization below!

==========

I authorize the review of my credit report by Northeast Georgia Health Systems. I understand that The Good News Clinics **cannot approve my care without this authorization.**

Signed _____ Date_____

Good News Clinics Application Process

Good News Clinics provides free medical and dental care to Hall County residents without insurance or access to healthcare who meet federal poverty level guidelines. Please read the following to ensure you have everything you will need to process your application.

THE FOLLOWING DOCUMENTATION IS REQUIRED TO APPLY

1. Picture ID of yourself
2. Proof that you live in Hall County. This could be a recent utility, cable, phone or hospital bill, rental lease, mortgage, etc, in your name.
3. Proof of your combined household income. This could include:
    a. Current pay stubs for the last four weeks.
    b. Unemployment benefits statement from Ga. Dept. Of Labor.
    c. Work history statement from the Ga. Dept. of Labor
    d. Social Security, disability, pension income statements, workman's comp benefits.
    e. Child support and/or alimony statements.
    f. Self employment income (will need recent tax return).
    g. Rental income.
    h. If you have a spouse who lives with you who has any of these types of income, we will also need proof of that income as well.

*NOTE: **If you have no income and someone other than a spouse is supporting you**, we must have the following documentation from this person:

Notarized letter from this person stating that they are supporting you and their proof of address. (*A copy of form is available from the receptionist. Have the person supporting you fill this out, sign it and have it notarized, and bring it in when you apply. If the person comes with you to apply, then the letter does not have to be notarized)*

4. If receiving food stamps, we will need DFCS verification letter.
5. If claiming children over 18 years of age as part of your household, you must provide active school enrollment/ID documentation.
6. Current tax return is required for medication **Patient Assistance Programs (PAP).**

Good News Clinics is open Monday – Friday, 8:30 AM-5:00 PM and provides the following services:

- Medical Clinic - provides ongoing medical care for our patients, including medications as prescribed by our physicians/providers
- Dental Clinic – provides a prevention program, extractions and fillings for our patients
- Health Access – specialty referral services for GNC patients
- Patients are seen by appointment

***Application times are as follows:**

Medical** applications are taken **Monday – Thursday on a sign-in basis at 8:30am on the Dental side.

Dental** applications are taken **Monday – Thursday on a sign-in basis at 8:30am

****If you are missing any of the above documentation we will not be able to process your application!**

GNC Financial Information Sheet

Name/*Nombre*:_____ Date/*Fecha*: _____

Home Phone#/*Numero Tel:* _____ SSN#/*Numero Seguro Social*_____

Name and phone # of Emergency Contact (person not living with you)/*Nombre de Contacto de Emergencia y numero de telefono (persona que no viva con usted)*:

Name/*Nombre*_____ Phone#/*Numero telefono*: _____

Relationship to Patient/Relacion al paciente_____

FAMILY SIZE: Adults_____ Under 18 _____ 18-21 Student _____ TOTAL FAMILY SIZE _____

Enter Full Name of Spouse and/or Legal Dependents, DOB, Relationship and Income

NAME/*Nombre*	DOB/*Fecha Nacimiento*	RELATIONSHIP TO "APPLICANT"/ *"Parentesco"*	GROSS EARNED INCOME (Last 4 wks) *To be completed by office staff only!!	GROSS UNEARNED INCOME (Last 4wks) *To be completed by office staff only!!
		SELF (Applicant)		
				TOTAL INCOME $

Patient Expenses/*Gastos del Paciente*

Rent: $_____
Electricity: $_____
Gas: $_____
Phone: $_____
Water: $_____
Cable: $_____
Cell Phone: $_____
Car: $_____
Car Insurance: $_____

Food: $_____
Other: $_____

Total Expenses: $_____

TANF (Food Stamps): _____
*(Do not include TANF in total expenses)

Last physician seen/*Quien fue el ultimo medico que vio?*_____

When/*Cuando*?_____

*Have you been to the ER or admitted within last 4 weeks? / *Ha estado en la sala de emergencia o hospital en las últimas cuatro semanas?* _____ Reason/*Razon*:_____

GOOD NEWS CLINICS MEDICAL HISTORY

BMI: _____ BP: _____

Date/Fecha: _____
Name/Nombre _____ Age/Edad: _____
Date of birth/Fecha de Nacimiento: _____ Sex/Sexo: _____
Reason for visit/Razon por la visita: _____

Are you taking any medication, drugs or pills/Esta tomando medicamento or drogas? _____
If yes, please list those drugs/Si es si, cuales: _____
_____
_____

How many times in the last year have you been to the emergency room? _____
Cuantas veces has estado en el cuarto de emergencia: _____

What did you go to the emergency room for?/Porque fue al cuarto de emergencia?
_____
_____
_____

SOCIAL HISTORY

	No	Yes/Si	In Past/En el pasado
Do you smoke?/Usted Fuma?			
Do you drink alcohol?/Toma bebidas alcholicas?			
Do you use drugs?/Usa drogas?			

FAMILY HISTORY/HISTORIA FAMILIAR

	If living; Age Si viven, Edad	Health/ Salud	If Deceased, age at death Si murieron, edad en que murieron?	Cause of death? Causa de muerte
Father/Padre				
Mother/Madre				
Brother/Hermano				
Sister/Hermana				
Spouse/Esposo/a				
Children/Hijos				

Has any blood relative ever had/Alguno de sus familiares han tenido ....

	No	Yes/Si	Who/Quien?
Cancer			
Diabetes			
Heart Trouble/Problemas Cardiacos			
Stroke/Derrame Cerebral			
High Blood Pressure/Hipertension sanguinea			
Seizures/Combulsiones			
Depression/Depresion			
Mental Illness/Enfermedad Mental			

ALLERGIES/ALERGIAS

Are you allergic to any medicines/Es usted alergico a algun medicamento. _____
Please list/por favor escriba cuales: _____
_____
_____

PERSONAL HISTORY/HISTORIA PERSONAL

Have you ever had/Usted ha tenido:	**Yes /Si**	**Have you ever had/Usted ha tenido:**	**Yes / Si**
Allergies (Alergias)		AIDS/HIV	
Anemia		Cholera (Cólera)	
Anticoagulation		Chicken Pox (Varicela)	
Arthritis (Artritis)		Dengue	
Asthma/COPD (Astma)		Ebola	
Bleeding (Sangrar)		Encephalitis	
Blood Plasma (Plasma sanguine)		Filariasis/Elephantitis	
Bowel Disease (Enfermedad del colon)			
Depression (Depresion)		Hepatitis	
Diabetes		Malaria	
Diarrhea (Diarrea)		Measles (Sarampion)	
Eye Disease (Enfermedad de ojo)		Mumps (Paperas)	
Epilepsy (Epilepsia)		Parasite Infection (Infección de parasite)	
GERD		Poliomyelitis	
Gout (Acido Urico/Gota)		Rheumatic Fever (Fiebre reumática)	
Hyperlipidemia		Scarlet Fever (Fiebre Escarlata)	
Hypertension (Alta Presion)		Tetanus (Tétano)	
Kidney Disease (Enfermedad de los riñones)			
Liver Disease (Enfermedad del Higado)		Tuberculosis	
Major Blood Vessel Disease (Enfermedad mayor de Vaso sanguine)		Whooping Cough (Tos convulsiva)	
Mental Illness (Enfermedad mental)			
Multiple Sclerosis or Nerve Disorder (e.g. Parkinson's)			
Migraines (Migrañas)			
Osteoporosis			
Thyroid (Tiroides)			
Transfusion (Transfusión)			
Stroke (infarto)			

Have you ever had/Usted ha tenido:	**Yes /Si**	**Explain**
Heart Disease? (Enfermedad del Corazon?)		
Cancer?		
Venereal Disease (STD)? (Enfermedad Venereas)		

PERSONAL HISTORY/HISTORIA PERSONAL

Have you ever had/Usted ha tenido:	No	Yes/Si
Broken Bones/Fractura de Huesos		
Severe head injury/Lesion severa en la cabeza		
Hospital Admissions/Admisiones al Hospital What year?/En que año? What reason?/Por que razon?		
Illness and/or operations. Please list year and reason: Enfermedad o operaciones/Año y razon:		

FOR WOMEN ONLY/SOLO PARA MUJERES	No	Yes/Si
Date of last menstruation period/Fecha de la ultima menstruacion:		
Regular cycle?/Ciclo regular o normal?		
Spotting/Con manchas		
Pain/Con Dolor		
Pre-menstrual dysphoric disorder (mood swings, irritability, tension, bloating) Desorden pre-menstruales (cambios repentinos de estado de animo, irritabilidad, tension, sensacion de inflamacion)		
Are you using birth control/Type Esta usando algun metodo anticontraceptivo?/Que tipo?		
Number of pregnancies?/Numero de embarazos		
Number of births/numero de partos		
Number of abortions/numero de abortos provocados		
Number of miscarriages/numero de abortos expantaneos		
Year of last Pap Test En que año se hizo el ultimo Papanicolau? Abnormal	☐ Normal	☐
Mammogram/Mamografia Abnormal	☐ Normal	☐
Breast Exam/Examen de los senos Abnormal	☐ Normal	☐
Bone Density Test/Examen de densidad de huesos Abnormal	☐ Normal	☐

IMPORTANT/IMPORTANTE!!!

Failure to come to your first appointment will result in a 12-month wait for a future medical appointment.

Si falta su primer cita, no podra ser visto hasta un año.

Good News Clinics Patient Needs Assessment

Patient Name _____ Date _____

Date of Birth _____ Telephone _____

What specific services are you looking for?

_____ Hunger relief

_____ Education

_____ Housing

_____ Financial help

_____ Veterans

_____ Jobs

_____ Counseling

_____ Medical Care

_____ Dental Care

_____ Other

Explain: _____

_____

_____

_____

_____

_____

What type of assistance have you received in the past or called to receive information on?

_____ Medicaid

_____ Disability

_____ Social Security

_____ Food Stamps

_____ Social Services

_____ Other

Explain: _____

_____

_____

Good News Clinics' Notes:

_____

_____

_____

_____

PHQ-9 Patient Questionnaire

Patient Name: _____ Date: ____/____/____

Date of Birth: ____/____/____ Telephone: ____-____-____

Gender: Male / Female Preferred Language: Spanish / English

For the Staff: Patient Chart Number _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

Questions	Not at all	Several Days	More than Half the days	Nearly Everyday
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling/staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed, or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

10. If you circled 1, 2, or 3 for *any* of the above questions, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? Please circle one of the following choices that best describes your level of difficulty over the past two weeks.	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Good News Clinics is now offering counseling! Counseling is where you can come in and talk to a trained professional about the things that have gone on in your life. A counselor can provide assistance in helping you cope with or resolve personal, social, or psychological issues.

Would you like to receive counseling? Please circle: Yes / No

Good News Clinics

Acknowledgement of Receipt of Privacy Notice/
Reconocimiento de Recibo de Aviso de Privacidad

Patient Name (*Nombre*): _____

Date of Birth (*Fecha Nacimeinto*): _____

By signing below, I acknowledge that I have received a copy of the Privacy Notice of Good News Clinics/ *Al firmar abajo, yo reconozco que he recibido una copia del Aviso de Privacidad de la Clinica Good News.*

_____
Signature of Patient or Legal Representative
Firma del Paciente (o) Representante Legal

_____
Print Name of Patient or Legal Representative
Escriba el Nombre del Paciente (o) Representante Legal

_____
Date/*Fecha*

Self
_____
Description of Legal Representative's Authority
Descripcion de Autoridad del Representante Legal

Name:_____
DOB:_____
Chart #:_____

Good News Clinics Policy and Procedures
No Show Policy

We understand that circumstances may arise that do not allow you to keep your appointment. Please remember to be courteous to us and the other patients by calling at least 24 hours prior to your appointment time to cancel if you cannot make it. This will allow us to place another patient in your spot. Patients arriving more than 15 minutes late for their appointments will be counted as a no show, and they will need to reschedule their appointments.

First missed appointment: One of our staff members will attempt to call you at the number listed in your chart to ask the reason for the no show. We understand that everyone forgets once in a while and will use this as a reminder.

Second missed appointments: Someone will attempt to contact you and ask the reason for the no show. You will receive a letter by mail and a note will be placed in your chart. This letter informs you that you have missed a second appointment and remind you of the consequences of missing a subsequent appointment.

Third missed appointment: Someone will attempt to contact you and advise you that you are no longer eligible for services. You will also receive a letter informing you that GNC will no longer be able to serve you as your primary health physician. We will provide medications only for the next 30 days until you find a new provider.

Health Access appointment: If Health Access has made an appointment for a specialty consult and you miss that appointment, you will not be eligible for rescheduling that consult. The same applies to missed imaging appointments.

Missed appointments cost us all, time, effort and money. If you have any questions, please ask any of the staff, or your doctor.

Patient Signature:_____ Date:_____

PATIENT MEDICAL CLINIC RESPONSIBILITES

1. I understand that The Good News Clinic is a non-profit organization funded solely by community donations, providing me free access to medical services. I also understand that I have the opportunity to assist the clinic through my personal donations at appointment times (donation boxes posted at sign-in windows and all exam rooms).

2. The Good News Clinic is for HALL COUNTY residents who have no insurance, and who cannot afford to go to the doctor and obtain medical care. I confirm that none of the information regarding my place of residence or finances has been falsified on my application.

3. Should I get insurance, it is my responsibility to inform the Good News Clinic and seek medical care elsewhere. I understand that I must report any changes of income to determine continued eligibility at the clinic. Failure to report changes in income or insurance, Medicaid, or Medicare eligibility is ground for immediate dismissal from the clinic.

4. I understand that appointment times are valuable and I must make every effort to keep my appointments, as scheduled. Please notify us 24 hours prior to your appointment if you will not be able to make it; otherwise, it will be counted as a broken appointment. If you do not show for your 1st appointment, you will not be able to be seen as a patient, and will not be eligible to re-apply for one year. Should you miss three scheduled appointments (NO SHOWS) and/or have excessive cancellations, you will be automatically discharged as a patient from the Good News Clinic and will not be eligible to re-apply again.

5. I understand that clinic doctors and nurses take the responsibility of providing me with medical care to the best of their ability, very seriously. I understand that I may have to wait for another appointment, due to the limited physician schedule.

6. I understand that it is my responsibility to cooperate in my medical treatment to improve my health. This may include stopping smoking/alcohol, losing weight, exercising, taking medication as instructed, keeping scheduled appointments and other instructions the doctor may give me. If I make no effort in my own health actions, I may be discharged from the clinic.

7. I understand that most of the people who work in the clinic are volunteering and not being paid for their time. I also understand they are here because they share the vision of the Good News Clinic and choose to be here to help me. I promise not to be rude to any staff but treat them with respect and dignity. Rudeness to the any staff member is ground for immediate dismissal from clinic.

8. I understand that occasionally, due to emergencies, I may not be seen at my appointment time or may be seen by a different doctor. I also understand that if I am late to my appointment, it is possible that I may not be seen that day.

9. I understand that the clinic operates on an appointment schedule and that if I walk in without a scheduled appointment, I will not be able to be seen, unless there is a cancellation.

10. I understand that if I have lab testing done, I will be notified of the results at my next appointment. Should results be abnormal and require a change in therapy, I will be notified by the nurse.

11. I understand that if I am referred to the hospital for additional testing, I will be responsible for the charges associated with this visit. I also understand that I am able to apply for the Indigent Care Program at the hospital for assistance with my bill.

12. I understand that, for safety reasons, children without appointments are not allowed in exam rooms - please make babysitting arrangements prior to appointment.

13. I understand that I must see the doctors in this clinic and that if I am seeing another doctor (unless referred by our clinic) I am not qualified to receive care here. If I start going to another doctor I must inform the clinic and have my care transferred to that medical provider. If the Good News Clinic discovers I am being seen by another physician, I will automatically be discharged from Good News Clinics. It is also absolutely against clinic policy to contact any of our Good News Clinic medical providers at their private practices. Anyone found doing so will be automatically dismissed from the clinic!!

SERVICES AVAILABLE

- MEDICAL – limited specialties.
- DENTAL – limited to fillings and extractions.
- GYN ONLY - (No OB/birth control services available - referred to Health Dept).
- OPTHALMALOGY – vision exams for established patients only **NOT AVAILABLE AT THIS TIME
- PHARMACY – Please call pharmacy for refills a few days before your medication runs out (refills will be ready for pick up after 1:00 pm the following day).
- CHAPLAIN/COUNSELING services.

PATIENT SIGNATURE: _____ DATE: _____

provide you with a report detailing the PHI about you contained in our designated record set. The Request to Access Protected Health Information form is available upon request. We may charge you a fee for the costs of copying, mailing and supplies that are necessary to fulfill your request. We may deny your request to inspect and copy in certain limited circumstances, if you are denied access to PHI about you, you may request that the denial be reviewed.

Request an amendment of PHI. If you feel that PHI we maintain about you is incomplete or incorrect, you may request that we amend it. You may request an amendment for as long as we maintain the PHI. To request an amendment, you must complete the Request to Amend a Record form and give it to an agency associate for review. If the request can be granted, then the agency associate will amend the appropriate record(s). The Request to Amend a Record form is available upon request. In certain cases, we may deny your request for amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with the decision and we may give a rebuttal to your statement.

Receive an accounting of disclosures of PHI. You have the right to receive an accounting of the disclosures we have made of PHI about you after April 14, 2003. This accounting includes only those disclosures required to be accounted for under the federal privacy standards for health information (45 C.F.R. Part 164). Those standards do not require accountings for disclosures for treatment, payment or health care operations purposes, among others. The accounting will exclude certain disclosures, such as disclosures made directly to you, disclosures you authorize, disclosures to friends or family members involved in your care, disclosures for notification purposes, and routine disclosures made to regulatory or law enforcement agencies. The right to receive an accounting is subject to certain other exceptions, restrictions, and limitations. To request an accounting, you must submit a request in writing to: ***(PRIVACY'S OFFICER'S NAME AND ADDRESS).*** Your request must specify the time period, but may not be longer than six years. The first accounting you request within a 12 month period will be provided free of charge, but you may be charged for the cost of providing additional accountings. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time.

Request communications of PHI by alternative means or at alternative locations. You have the right to request communications by alternative means or at alternative locations. For instance, you may request that we contact you about medical matters only in writing or at a different residence or post office box. To request confidential communication of PHI about you, you must complete the Request for Confidential Communications form and give it to an agency associate for review. If the request can be granted, then the agency associate will make the appropriate changes. We will accommodate all reasonable requests; however in case of emergency situations, we may contact you by whatever means we deem necessary. The Request for Confidential Communications form is available upon request.

Examples of How We May Use and Disclose PHI

The following are descriptions and examples of ways we use and disclose PHI:

We will use PHI for treatment. Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. **Example:** Information obtained by the agency will be used to dispense medications and/or treatment to you. We will document in your record information related to the medications and/or treatments dispensed to you and other services provided to you.

WE will use PHI for payment. Payment includes but is not limited to actions to make coverage determinations and receive payment (including billing, claims management, subrogation, plan reimbursement, and utilization review and pre-authorizations). **Example:** We will contact your Insurer to determine whether it will pay for your services and the amount of your co-payment. We will bill you or a third-party payor for the costs of services dispensed to you. The information on or accompanying the bill may include information that identifies you, as well as the medications you are taking.

We will use PHI for health care operations. Health care operations include but not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

Example: The agency may use information in your health record to monitor the performance of the agency providing treatment to you. This information will be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

We are likely to use or disclose PHI for the following purposes:

Business associates: There are some services provided t us through contacts with business associates. Example include Claims Processors or Administrators, Pharmac Benefit Managers, etc. When these services are contracte for, we may disclose PHI about you to our business associa so that they can perform the job we have asked them to c and bill you or your third-party payor for services rendere To protect PHI about you, we require the business associa to appropriately safeguard the PHI.

Communication with individuals involved in your care payment for your care: Health professionals, using the professional judgment, may disclose to a family membe other relative, close personal friend or any person you identif PHI relevant to that person's involvement in your care payment related to your care.

Health-related communications: We may contact you provide refill reminders or information about treatme alternatives or other health-related benefits and services th may be of interest to you.

Food and Drug Administration (FDA): We may disclose the FDA, or persons under the jurisdiction of the FDA, PH relative to adverse events with respect to drugs, food supplements, products and product defects, or post-marketir surveillance information to enable product recalls, repairs, replacement.

Workers' compensation: We may disclose PHI about yc as authorized by and as necessary to comply with law relating to workers' compensation or similar program established by law.

Public health: As required by law, we may disclose PH about you to public health or legal authorities charged wit preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose PHI about you for la enforcement purposes as required by law or in response to valid subpoena or other legal process.

As required by law: We must disclose PHI about you whe required to do so by law.

Health oversight activities: We may disclose PHI about yc to an oversight agency for activities authorized by law.

nspeccionar y obtener una copia de PHI. Usted tiene lerecho de tener acceso y copiar PHI acerca de usted :ontenida en un conjunto de registros designados mientras que a agencia mantenga su PHI. El conjunto de registros lesignados usualmente incluyen recetas y registros de acturación. Para inspeccionar o copiar PHI acerca de usted, usted debe completar el formulario Petición para Tener Acceso a Información Protegida de Salud y entregarlo a un socio de la agencia para revisión. Si la petición puede ser otorgada, entonces el socio de la agencia le proporcionará a usted un nforme detallando PHI acerca de usted contenida en nuestro conjunto de registros designados. El formulario de Petición para Tener Acceso a Información Protegida de Salud está disponible bajo petición. Podemos cobrarle por los costos de copiado, envío y suministros que sean necesarios para satisfacer su petición. Podemos negarle su petición a inspeccionar y copiar bajo ciertas circunstancias limitadas. Si a usted se le niega acceso a PHI acerca de usted, puede solicitar que la negación sea revisada.

Solicitar una enmienda de PHI. Si usted siente que PHI que mantenemos acerca de usted esta incompleta o incorrecta, usted puede solicitar que la enmendemos. Usted puede solicitar una enmienda durante el tiempo que mantengamos la PHI. Para solicitar una enmienda, usted debe completar el formulario Petición para Enmendar un Registro y entregarlo a un socio de la agencia para revisión. Si la petición puede ser otorgada, entonces el socio de la agencia enmendará el(los) registro(s) apropiado(s). El formulario Petición para Enmendar un Registro está disponible bajo petición. En ciertos casos, podemos negar su petición de enmienda. Si negamos su petición de enmienda, usted tiene el derecho de presentar una declaración de desacuerdo con la decisión y nosotros podemos refutar su declaración.

Recibir una rendición de cuentas de revelaciones de PHI. Usted tiene derecho de recibir una rendición de cuentas de las revelaciones que hemos hecho de PHI acerca de usted después del 14 de abril del 2003. Esta rendición de cuentas incluye solamente aquellas revelaciones requeridas a ser tomadas en cuenta bajo las normas federales de privacidad para la información de la salud (45 C.F.R. Parte 164). Esas normas no requieren tomar en cuenta las revelaciones para propósitos de tratamiento, pago, u operaciones de cuidado de salud, entre otras. La rendición de cuentas excluye ciertas revelaciones, como las revelaciones hechas directamente a usted, revelaciones que usted autorice, revelaciones a amigos o miembros de familia involucrados en su cuidado, revelaciones para propósito de notificación, y revelaciones rutinarias hechas a agencias reguladoras o policiales. El derecho a recibir una rendición de cuentas esta sujeto a ciertas excepciones, restricciones, y limitaciones. Para solicitar una rendición de cuentas, usted debe enviar una petición por escrito a: Cheryl Christian, 810 Pine Street, Gainesville, Georgia 30503. Su petición debe especificar el periodo de tiempo, pero no puede ser más de seis años. La primera rendición de cuentas que usted solicite dentro de un periodo de 12 meses será proporcionada gratis, pero puede cobrársele por el costo de proporcionar rendición de cuentas adicionales. Le notificaremos del costo involucrado y usted puede elegir renunciar o modificar su petición en ese tiempo.

Solicitar comunicados de PHI por medios alternativos o en ubicaciones alternativas. Usted tiene el derecho a solicitar comunicados por medios alternativos o en ubicaciones alternativas. Por ejemplo, usted puede solicitar que se le contacte acerca de cuestiones médicas solamente por escrito o a una residencia o apartado postal diferente. Para solicitar comunicados confidenciales de PHI acerca de usted, usted debe completar el formulario Petición para Comunicados Confidenciales y entregarlo a un socio de la agencia para revisión. Si la petición puede ser otorgada, entonces el socio de la agencia hará los cambios apropiados. Acomodaremos todas las peticiones razonables, no obstante en caso de situaciones de emergencia, quizá le contactemos por cualquier medio que creamos necesario. El formulario de Comunicados Confidenciales está disponible bajo petición.

Ejemplos de Cómo Podemos Utilizar y Revelar PHI

Las siguientes son descripciones y ejemplos de las maneras que utilizamos y revelamos PHI:

Utilizaremos PHI para tratamiento. Tratamiento es la provisión, coordinación o administración de cuidados de salud y servicios relacionados. También incluye pero no está limitado a consultas y referencias entre uno o más proveedores. Ejemplo: Información obtenida por la agencia será utilizada para proporcionar medicamentos y/o tratamiento a usted. Documentaremos en su registro información relacionada a los medicamentos y/o tratamientos y otros servicios proporcionados a usted.

Utilizaremos PHI para pagos. Pagos incluyen pero no están limitados a las acciones de hacer determinaciones de cobertura y recibir pagos. (incluyendo facturación, administración de reclamos, subrogación, plan de reembolso, y revisión de utilización y autorizaciones previas). Ejemplo: Nos pondremos en contacto con su seguro para determinar si pagará por sus servicios y la cantidad de su copago. Haremos factura a usted o a una tercera parte por los costos de los servicios proporcionados a usted. La información en o que acompaña la factura puede incluir información que le identifica a usted, así como los medicamentos que usted esté tomando.

Utilizaremos PHI para operaciones de cuidados de salud. Operaciones de cuidados de salud incluyen pero no están limitadas a evaluaciones y mejoras de calidad, revisión de competencias o calificaciones de profesionales de cuidados de salud, suscripción, clasificación de primas y otras actividades de seguro relacionadas a crear o renovar contratos de seguro. También incluye manejo de enfermedades, administración de casos, conducción o arreglo de revisiones médicas, servicios legales y funciones de auditoria incluyendo programas de observación de fraude y abuso, planificación y desarrollo de negocios, administración de negocios y actividades administrativas generales.

Ejemplo: La agencia puede utilizar información en su registro de salud para inspeccionar el desempeño de la agencia que proporciona el tratamiento a usted. Esta información será utilizada en un esfuerzo para mejorar continuamente la calidad y eficacia de los cuidados y servicios de salud que nosotros proporcionamos.

Posiblemente utilicemos o revelemos PHI para los siguientes propósitos:

Socios de negocios: Existen algunos servicios proporcionados por nosotros a través de contactos con socios de negocios. Ejemplos incluyen Procesadores o Administradores de reclamos, Gerentes de Beneficios de Farmacia, etc. Cuando estos servicios sean contratados, podemos revelar PHI acerca de usted a nuestros socios de negocios para que puedan desempeñar el trabajo que les hayamos pedido hacer y hacerle factura a usted o a su tercera parte por los servicios otorgados. Para proteger PHI acerca de usted, requerimos a nuestros socios de negocios que protejan PHI adecuadamente.

Comunicación con personas involucradas en su cuidado o pago para su cuidado: Los profesionales de salud, utilizando su juicio profesional, pueden revelar a un miembro de familia, otro pariente, amigo(a) personal cercano(a) o a alguna persona que usted identifique, PHI importante para la participación de esa persona en su cuidado o pago relacionado a su cuidado.

Comunicados relacionados a la salud: Podemos contactarle para proporcionar recordatorios de resuministro o información acerca de alternativas de tratamiento u otros beneficios relacionados a la salud y servicios que puedan ser de interés para usted.

La Administración de Drogas y Alimentos (FDA por sus siglas en inglés):

Podemos revelar a FDA, o a personas bajo la jurisdicción de FDA, PHI relacionada a eventos adversos con respecto a drogas, alimentos, suplementos, productos y defectos de productos, o información de vigilancia fuera del mercado para facilitar cuando un producto es quitado del mercado, reparaciones, o reemplazo de productos

Compensación laboral: Podemos revelar PHI acerca de usted, autorizado por y como sea necesario, para conformar con las leyes relacionadas a compensación laboral o programas similares establecidos por ley.

Salud pública: Como se requiere por ley, podemos revelar PHI acerca de usted a autoridades legales o de salud pública encargadas de prevenir o controlar enfermedades, lesiones, o discapacidades.

Policía: Podemos revelar PHI acerca de usted para propósitos policiales como se requiere por ley o en respuesta a un citatorio judicial válido u otros procesos legales.

Como se requiera por ley: Debemos revelar PHI acerca de usted cuando se requiera hacerlo por ley.

Actividades de supervisión de la salud: Podemos revelar PHI acerca de usted a una agencia supervisora para actividades autorizadas por ley.