Sliding Fee Discount Application

Community Health Connection **DOES NOT OFFER FREE SERVICES**. However, patients may apply for the Sliding Fee Discount Program. Those who qualify will be offered a discount that is based on the GROSS income of ALL members of the household. To apply for this discount, patients **must** complete the following information **and** provide copies of the following documents:

- Proof of Income (choose one of the following):
  - Two most recent check stubs (within 30 days) **or**
  - Unearned income (Veteran's/ Military benefits, Social Security benefits, SSI, SSA, Child Support, etc.) **or**
  - Letter from employer, on company letterhead, indicating gross income and frequency of pay **or**
  - Notarized letter from employer indicating gross income and frequency of pay or
  - Most recent tax return (Forms 1040,1040-EZ, or 1040-A) if self-employed or if no other verification of income is available.
- Proof of Address (i.e. utility bill) (Responsible party if pediatric patient)
- All patients/responsible party must have photo identification

All patients will be responsible for the full cost of services provided unless the required documents (listed above) are presented with the completed application.

The Sliding Fee Discount Program expires after one year.

Patient/Responsible Party Name (please print): ______________________

Patient's Date of Birth: ______________________

Patient/Responsible Party Telephone Number: ______________________

Street address, City, State, Zip Code: ______________________

Current Employer (Name & telephone number): ______________________

Please list all household members below (including yourself):

Name	Date of Birth	Income/Frequency

Ellen Ochoa 12020 East 31st Street **Kendall-Whittier** 2321 East 3rd Street **Rosa Parks** 13702 East 46th Place South **Youth Services** 1001-A East 3rd Street
918.622.0641 • communityhealthconnection.org

By submitting this application and signing below you are certifying that:

- Information provided by you in this Sliding Fee Discount Application is true and correct.
- Payment is required on the date of service. You are required to pay an estimate of your portion of the Practitioner Visit and/or anticipated labs prior to being seen. If there are additional services, labs and/or procedures performed during your visit, you will be asked to pay for those at your time of departure.
- If for any reason you are unable to pay for your entire visit, payment arrangements may be available. Let the Front Desk staff know who will refer you to the Patient Account Specialist to discuss your options.
- You understand that eligibility in the Sliding Fee Discount Program is valid for one year.
- You are obligated to notify CHC of any changes in your income or household status.

________________________________ ________________________________

Patient or Resposible Person's Signature Date

BELOW TO BE COMPLETED BY FROND DESK STAFF ONLY

Gross Income listed above: ____________________ ○ Daily ○ Weekly ○ Bi-Weekly ○ Monthly ○ Annually

Total Number of Dependents listed above: ____________________

Poverty Level: ____________________ (as calculated by eCW)

Assigned Sliding fee Schedule: ____________________ (as calculated by eCW)

Expiration Date: ____________________ Date Approved: ____________________

Reviewed and Approved (Front Desk Staff Initials): ____________________

Front Desk Staff:

- Verify that application is fully completed and signed by the patient.
- Complete "Office Use Only" section and indicate Poverty Level and Sliding Fee Category as calculated by eCW.
- Initial (legibly) and date for indicating you have reviewed document for completeness.
- Scan document into eCW
- Provide patient with completed and signed copy.

NEW PATIENT REGISTRATION FORM

General Information (Please Print)

Date | Name (Last, First, Middle)

Other Names/Maiden Name/Also Know As (Last, First, Middle) | Date of Birth (Month/Day/Year)

Social Security Number

Please indicate the gender you most closely identify with
○ Male ○ Female ○ Transgender Female (Male to Female) ○ Transgender Male (Female to Male) ○ Other ○ Choose not to Disclose

Please Indicate your Sexual Orientation
○ Lesbian/Gay ○ Straight ○ Bisexual ○ Don't Know ○ Something Else ○ Choose not to Disclose

Marital Status
○ Single ○ Married ○ Widowed ○ Divorced

Ethnicity
○ Hispanic ○ Not Hispanic

Race (Please Check all that Apply)
○ American Indian/Alaska Native ○ Asian ○ Black or African American ○ White ○ Other Pacific Islander ○ Native Hawaiian

Home Address | Apt.

City | State | Zip Code | Home Phone Number

Work Phone Number | Cell Phone Number | Email Address

Preferred Contact Method
○ Phone ○ Email ○ Mail

Are you a Veteran?
○ Yes ○ No

If yes, what branch of Military Service?

Employment
○ Full-time ○ Part-time ○ Seasonal ○ Migrant

Employer | Occupation

Employer Address | City | State | Zip Code

Annual Income* | Number of People in Household*

**This information is used for Federal grant reporting purposes only and will not affect what we charge for your visit.*

How did you hear about Community Health Connection?
○ Family/Friend ○ Health Fair/Event/Outreach ○ Newspaper/Magazine ○ Radio ○ TV ○ Website/Social Media ○ Other Advertising ○ Referral from another Provider

Emergency Contact Information

Emergency Contact Name | Relationship to Patient

Home Phone Number | Work Phone Number | Cell Phone Number

Insurance Information (Primary)

Insurance Company Name/Medicaid/Medicare | Address

City | State | Zip Code | Phone Number

Effective/Issue Date | Group Number | Member Number/Claim Number | Patients Relationship to Subscriber

Subscriber's Name | Subscriber's Employer

Insurance Information (Secondary)

Insurance Company Name/Medicaid/Medicare | Address

City | State | Zip Code | Phone Number

Effective/Issue Date | Group Number | Member Number/Claim Number | Patients Relationship to Subscriber

Subscriber's Name | Subscriber's Employer

AUTHORIZATION FOR DENTAL TREATMENT/BILLING/RELEASE OF INFORMATION

Community Health Connection, Inc. (CHC) personnel are hereby authorized to administer any dentall, diagnostic or therapeutic treatment, as may be deemed necessary or advisable. I have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

I understand and agree that I am ultimately responsible for the balance on my account for any professional service(s)rendered. I have completed the above questions on page 1 and 2 of this packet and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my insurance status or any of the above information. I request that payment of authorized medical benefits, if any, be made to Community Health Connection, Inc. (CHC) on my behalf for any unpaid service(s) rendered by CHC.

I authorize the release of medical information to the health plan(s) indicated for information requested by the health plan(s) to determine the payment of medical benefits. The information authorized for release may include information about communicable or noncommunicable disease, mental health, substance or alcohol abuse.

Signature of Patient/Authorized Representative* Date

NO SHOW/LATE CANCELLATION/RESCHEDULE

As of July 1, 2024, patients will only be allowed four (4) appointment "no-shows**" in a rolling year or within the last 12 months. After the fourth no-show, patients will become inactive and will be considered a "walk-in basis" patient only. Once patient is seen, patient will be returned to Community Health Connection's (CHC's) standard scheduling practice.

*** No-show means not attending an appointment without notice or calling to cancel/reschedule an appointment with less than twenty-four (24) hours advance notice. Exceptions may be made in case of an emergency.*

I have read the above notice and agree to abide by the policy.

Signature of Patient/Authorized Representative* Date

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Community Health Connection, Inc.'s (CHC's) Notice of Privacy Practices (Notice), and I consent to the use of my protected health information (PHI) for treatment, payment, and health care operations CHC has summarized in the Notice. ***I understand that I may refuse to sign this acknowledgment.***

Patient/Authorized Representative* (Please Print) Relationship to Patient

Patient/Authorized Representative* (Signature) Date

PATIENT PHOTO CONSENT

I, (Please Print)____, give Community Health Connection permission to record my image (photograph) for the purpose of identification.

I understand the recording of my image is not a condition of receiving services at Community Health Connection and I may deny having my picture taken.

I understand this picture is to be used for identification purposes only and will only be used inside Community Health Connection.

Patient/Authorized Representative* (Please Print) Relationship to Patient

Patient/Authorized Representative* (Signature) Date

May be required to show proof of Representative Status

Dental Medical History

Last Name	First Name	Middle Name	Today's Date	Social Security Number

Date of Birth	Height	Weight	Phone Number	Work Phone

For the following questions, check YES or NO, whichever applies. Your answers are for our records only and will be considered confidential.

Question	Answer
Are you in good health?	☐ YES ☐ NO
Has there been any change in your general health within the past year?	☐ YES ☐ NO
Are you now under the care of a physician?	☐ YES ☐ NO
Your physician's name, address and phone number:	
Have you had any serious illnesses or operations?	☐ YES ☐ NO
If yes, what is the illness or operation?	
Do you have, or have you had any of the following diseases or problems?	
Damaged heart valves or artificial heart valves, including heart murmurs	☐ YES ☐ NO
Congenital heart lesions	☐ YES ☐ NO
Cardiovascular disease, heart trouble, heart attack, coronary insufficiency?	☐ YES ☐ NO
Coronary occlusion, high blood pressure, arteriosclerosis, stress?	☐ YES ☐ NO
Are you ever short of breath after mild exercise?	☐ YES ☐ NO
Do you have a cardiac pacemaker?	☐ YES ☐ NO
Allergies?	☐ YES ☐ NO
Sinus trouble?	☐ YES ☐ NO
Asthma or hay fever?	☐ YES ☐ NO
Hives or skin rash?	☐ YES ☐ NO
Fainting spells, seizures or epilepsy?	☐ YES ☐ NO
Diabetes?	☐ YES ☐ NO
Does your mouth frequently become dry?	☐ YES ☐ NO
Hepatitis, jaundice or liver disease?	☐ YES ☐ NO
Arthritis or inflammatory rheumatism (painful swollen joints)?	☐ YES ☐ NO
Kidney trouble?	☐ YES ☐ NO
Tuberculosis?	☐ YES ☐ NO
Do you have a persistent cough or cough up blood?	☐ YES ☐ NO
Low blood pressure?	☐ YES ☐ NO
Sexually transmitted diseases (Gonorrhea, Syphilis, Genital Herpes)?	☐ YES ☐ NO
Psychiatric problems?	☐ YES ☐ NO
Cancer or Leukemia?	☐ YES ☐ NO
AIDS or other immunosuppressive disorder?	☐ YES ☐ NO
Other:	
Have you had abnormal bleeding associated with previous extractions, surgery or trauma?	☐ YES ☐ NO
Do you bruise easily?	☐ YES ☐ NO
Have you required a blood transfusion?	☐ YES ☐ NO
If yes, please explain:	

Do you have any blood disorders, such as anemia or sickle cell disease?	☐ YES ☐ NO
Do you smoke or use smokeless tobacco?	☐ YES ☐ NO
Do you consume alcohol on a daily basis?	☐ YES ☐ NO
Have you ever used drugs; cocaine, marijuana, perscirption drugs, etc. for recreation purposes?	☐ YES ☐ NO
Have you had surgery, x-ray or drug treatment for a tumor, growth or other condition on your head or neck?	☐ YES ☐ NO
Please list all medications you are currently taking:	
Please list any allergies that you might have:	
Have you had serious trouble associated with any previous dental treatments?	☐ YES ☐ NO
Do you have any disease, condition or problem listed above that you think we should know about?	☐ YES ☐ NO
If yes, please explain:	
Are you pregnant?	☐ YES ☐ NO
Do you have any problems associated with your menstrual period?	☐ YES ☐ NO
Are you nursing?	☐ YES ☐ NO
Chief dental complaint (please list):	
Are you currently having problems with dental pain or pain management?	☐ YES ☐ NO
If yes, how severe is the pain on a scale of 1-5 (with 5 being the worst pain)?	1 2 3 4 5

I certify that I have read and understand the above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Patient's Guardian	Date	Signature of Dentist	Date

NOTICE OF HEALTH INFORMATION 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 THIS NOTICE CAREFULLY.

If you have any questions about this notice, please contact Community Health Connection's (CHC's) Privacy Official at (918) 622-0641.

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION

We understand that health information about you and your healthcare is personal. We are committed to protecting health information about you. We will create a record of the care and services you receive from us. We do so to provide you with the quality care and to comply with any legal or regulatory requirements. This Notice applies to all of the records generated or received by CHC, whether we documented the health information, or another doctor forwarded it to us.

This Notice will tell you the ways in which we may use or disclose health information about you. This Notice also describes your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

Our pledge regarding your health information is supported by Federal law. The privacy and security provisions of the Health Insurance Portability and Accountability Act ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") require us to:

- Make sure that health information that identifies you is kept private;
- Make available this notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures

You have the right to request a list (accounting) of any disclosures of your health information we have made, except for uses and disclosures (i) for treatment, payment, and health care operations, (ii) to individuals of protected health information about them, (iii) incident to a use or disclosure otherwise permitted or required by this law, (iv) pursuant to an authorization signed by you, (v) for the facility's directory or to persons involved in your care, (vi) for national security or intelligence purposes, (vii) to correctional institutions or law enforcement officials.

To request this list of disclosures, you must submit your request on a form that we will provide to you. Your request must state a time period that may not be longer than six (6) years prior to the date on which the accounting is requested. The first list of disclosures you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures in paper form within sixty (60) days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; but this date should not exceed a total of ninety (90) days from the date you made the request.

Right to Request Restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. For example, you could ask that access to your health information be denied to a particular member of our workforce who is known to you personally.

While we will try to accommodate your request for restrictions, we are not required to do so if it is not feasible for us to ensure our compliance with law or we believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or you agree to terminate the restriction. To request a restriction, you must make your request on a form that we will provide you. In your request, you must tell us what information you want to limit and to whom you want the limits to apply.

Right to Request Confidential Communications
You have the right to request that we communicate with you about health matters in a certain manner or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box. During our intake process, we will ask you how you wish to receive communications about your health care or for any other instructions on notifying you about your health information and you agree to provide information as to how payment will be handled and specify an alternative address or other method of contact. We will accommodate all reasonable requests, provided that you have supplied information to us as to how payment will be handled and you have specified an alternative address or other method of contact.

Right to a Paper copy of This Notice
You have the right to obtain a paper copy of this Notice at any time upon request. You may also obtain a copy of this Notice on our web site (www.communityhealthconnection.org).

SPECIAL SITUATIONS
Minors and Persons with Guardians
Minors have all the rights outlined in this Notice with respect to health information relating to reproductive health care, except in emergency situations or when the law requires reporting of abuse and neglect. If you are a minor or a person with a guardian obtaining healthcare that is not related to reproductive health, your parent or legal guardian may have the right to access your medical record and make decisions regarding the uses and disclosures of your health information.

Military and Veterans
If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release medical information about you to comply with laws relating to workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose medical information about you for public health activities. These activities generally include the following:
- to prevent or control disease, injury, or disability;
- to report births and deaths or conduct public health investigations;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- for health oversight activities;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Lawsuits and Disputes
We may disclose medical information about you in the course of any judicial or administrative proceeding in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process if we (i) have received assurance that the party seeking the information has made reasonable efforts to give you notice of the request and you have not objected or the party seeking the information has secured a qualified protective order, or (ii) have made reasonable efforts to provide notice of the request to you or have sought a qualified protective order.

Law Enforcement
We may release medical information if asked to do so by a law enforcement official:
- As required by law;
- In response to a court order, subpoena, warrant, summons, or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, the individual agrees or we are unable to obtain the person's agree ment because of incapacity or emergency;

- About a death we believe may be the result of criminal conduct;
- In an instance of criminal conduct at our facility; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Coroners, Health Examiners and Funeral Directors
We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

Inmates
If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary: (1) for the institution to provide you with healthcare; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU
You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy
You have certain rights to inspect and copy health information about you that may be used to make decisions about your care. Usually, this includes health and billing records and is information contained in a designated record set. This does not include psychotherapy notes, information compiled in anticipation of or use in a civil, criminal or administration action or proceeding, or information that is subject to or exempt from the Clinical Laboratory Improvements Amendment of 1988.

To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing on a form provided by us to: "The Privacy Official at CHC" at the address provided on the first page of this Notice. If you request a copy of your health information, we may charge a fee for the costs of copying (including supplies for and labor of copying), mailing, and preparing an explanation or summary of the health information (if you have requested such a summary and have agreed to such cost). We may deny your request to inspect and copy in limited circumstances. If you are denied access to health information, in certain instances you may request that the denial be reviewed. In instances where you may request that the denial be reviewed, another licensed healthcare professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who denied your initial request. We will comply with the outcome of the review.

Right to Amend
If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing on a form provided by us and submitted to: "The Privacy Official at CHC."

We may deny your request for an amendment if it is not the form provided by us and does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for our practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

HOW WE MAY USE AND DISCLOSE HEALTH INFROMATION ABOUT YOU
The following categories describe different ways that we may use or disclose health information about you. Unless otherwise noted each of these uses and disclosures may be made without your permission. For each category of use or disclosure, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, unless we ask for a separate authorization all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment
We may use health information about you to provide you with healthcare treatment and services. We may disclose health information about you to doctors, nurses, technicians, health students, volunteers or other personnel who are involved in taking care of you. They may work at our offices, at a hospital if you are hospitalized under our supervision, or at another doctor's office, lab, pharmacy, or other healthcare provider to whom we may refer you for consultation, to take x-rays, to perform lab tests, to have prescriptions filled, or for other treatment purposes. For example, a doctor treating you may need to know if you have diabetes, because diabetes may slow the healing process. We may provide that information to a physician treating you at another institution.

Additionally, CHC may participate in an electronic health information exchange with other healthcare provider members, in which we send patient data to a network system committed to securing the information and allowing your data to be available to another member who is providing treatment to you. You may choose to not participate in, or 'opt out,' of this electronic health information exchange at any time.

For Payment
We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, and a state Medicaid agency or a third party. For example, we may need to give your health insurance plan information about your office visit so your health plan will pay us or reimburse you for the visit. Alternatively, we may need to give your health information to the state Medicaid agency so that we may be reimbursed for providing services to you. In some instances, we may need to tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Healthcare Operations
We may use and disclose health information about you for operations of our healthcare practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study healthcare delivery without learning who our specific patients are.

Appointment Reminders
We may use and disclose health information to contact you as a reminder that you have an appointment. Please let us know if you do not wish to have us contact you concerning your appointment, or if you wish to have us use a different telephone number or address to contact you for this purpose.

Fundraising Activities
We may use health information about you to contact you in an effort to raise money for our not-for-profit operations. Please let us know if you do not want us to contact you for such fundraising efforts.

Research
There may be situations where we want to use and disclose health information about you for research purposes. For example, a research project may involve comparing the efficacy of one medication over another. For any research project that uses your health information, we will either obtain an authorization from you or ask an Institutional Review or Privacy Board to waive the requirement to obtain authorization. A waiver of authorization will be based upon assurances from a review board that the researchers will adequately protect your health information.

CHANGES TO THIS NOTICE
We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in our facility and on our website and you may request a paper copy of the Notice. The Notice contains the effective date at the bottom of each page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us and with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact: “The Privacy Official at CHC” at the address on the first page of this Notice. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain the records of the care that we provided to you.

A PATIENT'S GUIDE TO MYHEALTH

WE ARE USING INFORMATION TECHNOLOGY TO HELP YOU As Community Health Connection, Inc. (CHC) keeps pace with advancements in health care, we have a growing need to safely and efficiently use computers to electronically share your health information with the team of health professionals who provide care to you.

Currently, when we need to share your health information with other health providers the process is difficult and usuallymeans numerous phone calls, mailings and faxes. And, when we need to gather information from one of your other providers it can take hours or even weeks and sometimes the information is not available at all. Technology can help us do better.

MEET OUR NEW PARTNER, MYHEALTH ACCESS NETWORK.
MyHealth Access Network (MyHealth) is a non-profit coalition of Oklahoma health providers, including doctors, hospitals, labs, pharmacies, emergency services and other health industry professionals, who are using technology to link medical providers, exchange timely information and improve the delivery of local health care. MyHealth allows us to deliver the right information to the right doctor, at the right time, to help care for you.

FREQUENTLY ASKED QUESTIONS
Although MyHealth is designed to be used by health care professionals, it provides many important benefits and choices for you. We've attempted to answer the most common questions here:

WHO CAN ACCESS MY INFORMATION?
Only the health industry professionals involved in your care (and their approved staff members) that belong to the MyHealth network can access your information, and only as their jobs require it.

WHAT ARE SOME EXAMPLES OF HOW MyHealth HELPS ME?
Time is important when addressing your health needs. Some examples of when and how your personal health information is used to help you include:

- When you see a medical specialist, your doctor and the specialist need to share your information to help coordinate effective care. The quicker this happens, the quicker you receive the care you need.
- In a medical emergency such as a car accident, ambulance and emergency room doctors can have access to important health information that might save your life or that of a loved one; like a medication list, drug and food allergies, presence of a pacemaker, etc.
- If you manage care for yourself, a child, parent, etc., then you know the challenges of keeping up with medication lists, procedures, allergies, and vaccinations. MyHealth can help make these available in the doctor's office.

WHAT HEALTH INFORMATION IS STORED IN MYHELATH ACCESS NETWORK?
Only high priority health information is included in MyHealth Access Network. This includes:

- Names of the doctors and other health professionals who provide your care.
- Past procedures
- Diagnoses
- Known allergies
- Current prescribed medications
- Immunization records
- Lab and x-ray results
- Basic personal information (name, address, contact information, etc.)

HOW DOES MY INFORMATION STAY SECURE?

We take your privacy very seriously, and information shared through MyHealth is protected with the highest forms of security, including encryption and secured connections. We know that patients must trust their information is safe. MyHealth complies with all State and Federal laws (like HIPAA) to protect your information.

DO I NEED TO SIGN UP FOR THIS SERVICE?

No. Because CHC is a participating MyHealth partner you are included in the network. You may opt out if you wish (see how below).

CAN I CHOOSE NOT TO PARTICIPATE IN MYHEALTH?

Yes, you can choose to not participate in, or 'opt out' of MyHealth at any time. Choosing to opt out generally means that your doctors will not be able to use the MyHealth network to electronically access your health information. You can opt out of MyHealth by:

1. Obtaining an Opt Out of MyHealth Form from our front desk clerk, or by downloading the form from www.myhealthaccess.net/opt-out
2. Complete the form (please wait to sign it in front of our desk clerk)
3. Bring the form to our front desk clerk and sign it with our clerk as a witness. We will send it to MyHealth for you OR you may sign your form with a Notary Public as a witness and mail it to the address provided on the form.

You can always return to MyHealth by completing the Return to MyHealth Form which is also available from our front desk clerk, or online at www.myhealthaccess.net/opt-in

WHO IS MYHEALTH ACCESS NETWORK?

MyHealth is an Oklahoma non-profit organization created by patients, doctors, hospitals, emergency responders, insurance plans, and other organizations providing health care to Oklahomans. To learn more about MyHealth, visit www.myhealthaccess.net.

WHO DO I CONTACT FOR MORE INFORMATION OR SUPPORT?

If you would like more information about MyHealth, please visit: www.myhealthaccess.net or call 918-236-3451.