Citizen Potawatomi Nation Health Services

New Patient Packet – Adult

On behalf of the providers and staff of Citizen Potawatomi Nation Health Services, we welcome you to our practice. We are honored that you have entrusted us with your care. Included in this packet you will find a new patient form, information on Purchased Referred Care (formally Contract Health), as well as disclosure and confidentiality forms.

The documents listed below should be submitted with your new patient paperwork. As a tribally operated facility, these documents allow us to determine if the patient meets eligibility requirements for care within our clinics. Failure to include or provide the requested documents will result in delays in access to services within our facilities.

Native American Adults	**CPN Spouses (non-native spouse of a CPN tribal member)**	**CPN Employees and their adult dependents**
CDIB or Tribal enrollment card	Spouse's CPN tribal enrollment card	Employee ID
Social Security Card	Social Security Card	Social Security Card
Driver's License or state ID	Driver's License or state ID	Driver's License or state ID
Health insurance card (front and Back)	Health insurance card (front and Back)	Health insurance card (front and Back)
	Marriage License	

If you need assistance completing new patient paperwork or have questions, please call or visit one of the Citizen Potawatomi Nation Health Services clinics listed below. Completed forms and documents may be returned to either clinic facility.

East Clinic
2307 S. Gordon Cooper Dr.
Shawnee, OK 74801
405-273-5236

West Clinic
781 Grand Casino Blvd.
Shawnee, OK 74804
405-964-5770

Sincerely,

Citizen Potawatomi Nation Health Services Administration

THE CITIZEN POTAWATOMI NATION

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

As a patient of Citizen Potawatomi Nation Health Services, you have the right to:

- Timely access to medical and health-related services which meet standards of care, and which are delivered with respect and recognition of your cultural and spiritual values.
- A patient/practitioner relationship conducted in an environment where your privacy and the confidentiality of your relationship are guarded by every employee.
- A clear explanation of your condition, diagnoses, treatment plan, therapy options, and prognosis.
- Participate in decisions about your care and receive clear answers to your questions.
- Refuse treatment and to receive an explanation of the consequences of your refusal.
- An explanation of charges levied for your care, and how reimbursement issues will be resolved.
- Make comments or complaints concerning your care and to have your inputs acted upon.
- Know the professional standing and licensure status of individuals providing your care.
- Decide for yourself whether or not you will participate in clinical trials or investigative studies without fear of retribution of any kind.
- An explanation of Advance Directives for Healthcare (Living Wills), appointing someone you trust to help you make decisions on your care.

In addition to the rights listed above, it is your responsibility to:

- Give your practitioners complete and accurate information about your personal and family medical history, present health status, and other information needed to make prompt, accurate diagnoses.
- Notify your practitioner if you don't understand your condition, treatment plan, instructions for taking medications, or other information given to you by your care givers and counselors.
- Follow instructions, treatment plans, and therapy regimens given to you by CPNHS practitioners.
- Inform clinic staff when you obtain or lose health benefit coverage.
- Pay billed charges in a timely manner, health insurance and tribal benefit will be applied (if applicable).
- Keep appointments or notify the clinic at least 24 hours prior if you must cancel an appointment.
- Conduct your visit in a manner which fosters good order and consideration of others.
- Adhere to the established COVID-19 policies of CPN Health Services.

For questions, comments, or concerns please contact CPNHS Clinic Operations Managers at:

East Clinic	**West Clinic**	**Specialty/Imaging Clinic**
(405) 273-5236	(405) 964-5770	(405) 695-6003

PURCHASED/REFERRED CARE (PRC)

Previously known as Contract Health

What is Purchased/Referred Care?

Purchased/Referred Care (PRC) exists to supplement or complement other health care resources available to Native Americans. PRC funds are used when no direct care exists or is not capable of providing required emergency and/or specialty care.

PRC is required to operate within appropriated funds. There is no requirement to provide payment for services under the PRC program unless funds are available.

PRC is not:

- An Entitlement Program
- An Insurance Program

Does CPN PRC have unlimited funds?

No. PRC resources are based on a limited congressional appropriation (or budget).

When are PRC funds used?

PRC funds are used in situations where:

- No IHS direct care facility exists.
- The direct care facility cannot provide the required specialty care.
- The direct care facility has an overflow of medical care workload.

PRC is limited to services that are medically indicated within the established medical priorities.

If services are not authorized for payment, they will be denied or deferred.

Previously known as Contract Health, PRC is available in the event services are required beyond what is offered at CPNHS, your primary provider may refer you for services outside of the clinic. With an approved referral and current proof of residency- Purchased/Referred Care (PRC) funds may cover the cost for these medical services and some additional services. The expenditure of PRC services is based on medical necessity and current funding level. Each patient will be assigned to a PRC patient referral clerk based on their last name and insurance. Patients are responsible for notifying referral clerks of all outside appointments prior to the appointment date. Failure to notify may result in denial of payment. Authorized office visit referrals are

generally limited to 3 appointments per referral. If continued care is needed beyond the limit set forth a new referral will need to be obtained. If a procedure, surgical or non has been requested by your provider, a separate referral will need to be placed for review. All non-emergent procedures and surgeries require an approved referral prior to scheduling.

PRC eligibility requirements are listed below:

CPN tribal members- Enrolled CPN tribal members who can provide proof of residency within the designated catchment area will be eligible to receive services through PRC.

CPN tribal members must reside within the PRC catchment area of Pottawatomie, Cleveland, Oklahoma, Logan, and Lincoln Counties.

Native Non-CPN member (member of other federally recognized tribe)- must live within the CPN PRC catchment area- **south of the North Canadian River, north of the Canadian River, East of Indian Meridian Road, and west of the Pottawatomie County/Seminole County line.**

***Patients who do not live in the CPN service area will have all referrals forwarded to their service area to be reviewed and processed.

For all CPN PRC patients, evidence must exist that an alternate resource, such as Medicaid, has been applied for. Such evidence is mandatory and will be obtained once per year due to Federal regulations that require PRC funding only to be used after all other alternative resources have paid. Each patient without a secondary payer will need to apply for Medicaid through a Benefits Specialist- located at your clinic.

If you have private insurance, please notify PRC at least 48-hours prior to your appointment date for a Coordination of Benefits to be sent to the provider.

In the case of **emergency room visits**, PRC will need to be **notified within 72 hours** to determine eligibility for payment and must be deemed medically necessary. Medical priorities have been established for determining which referrals can be authorized for payment. Notification does not assure authorization of payment. However, if you do not notify PRC within 72 hours, your bill(s) will not be paid.

Please note that IHS facility emergency room visits are of no cost to patients. Locations include CNMC in Ada, Creek Nation in Okemah, Clinton, Lawton, and Claremore.

****If you receive a bill from a provider, please provide a copy to PRC as soon as possible. You may bring bills to the CPN PRC office located on the 3rd floor of the old Mission Hill Hospital. Please enter on the North side.**

CPN PURCHASED/REFERRED CARE
1900 S. GORDON COOPER DR.
SHAWNEE, OK 74801
P: (405) 964-4123

Can PRC pay for your referral medical care? Find out in 3 stages.

Individual Qualifications

Stage 1
You are eligible if:

a) You are a member or descendent of a Federally recognized Tribe or have close ties acknowledged by your Tribe*

and

b) You live on the reservation or, if you live outside the reservation, you live in a county of the PRCDA for your Tribe*

Each Purchased/Referred Care Delivery Area (PRCDA) covers a single Tribe or a few Tribes local to the area. You are ineligible for PRC elsewhere.*

and

c) You get prior approval for each case of needed medical service or give notice within 72 hours in emergency cases (30 days for elders & disabled)

Yes for all

No for the above

Application is denied.

* There are a few narrowly defined exceptions. Ask PRC staff for more specifics about individual eligibility, PRCDA, or prior notice.

Relative Medical Priorities

Stage 2
Payment may be approved if:

a) The health care service that you need is medically necessary

– as indicated by medical documentation provided

and

b) The service is not available at an accessible IHS or Tribal facility

and

c) The facility's PRC committee determines that your case is within the current medical priorities of the facility

Unfortunately, PRC funds often are not sufficient to pay for all needed services. When this happens, the committee considers each individual's medical condition to rank cases in relative medical priority. Cases with imminent threats to life, limb, or senses are ranked highest in priority. **

and

d) PRC funds available are sufficient to pay for the service to be authorized

Yes for all

No for the above

Application is deferred.

** Ask PRC staff for more specifics. Sometimes deferred lower priority cases may be reconsidered later if funding permits.

Coordination and Payment

Stage 3
Approval, Billing, Payment

a) You must apply for any alternate resources for which you may be eligible
– Medicare, Medicaid, insurance, etc.

then

b) A PRC purchase order is issued to a provider authorizing payment for services

then

c) IHS or Tribal staff and the authorized provider coordinate your medical care

then

d) The authorized provider bills and collects from your alternate resources

then

e) The authorized provider bills any unpaid balance to PRC for payment
– because PRC is payer of last resort, it pays only for costs not paid by your alternate resources

Steps are completed in order

Provider is paid.

Specific services authorized within relative medical priorities may vary from time-to-time in response to changing supply and demand, especially to stretch diminished funds over the remainder of the fiscal year.

Generally applicable Purchased/Referred Care (PRC) rules and procedures are shown. Some nuances and exceptions are omitted. Talk to PRC staff if you have questions.

DATE REC'D:_____ Chart #_____

CITIZEN POTAWATOMI NATION HEALTH SERVICES
ADULT INTAKE FORM

PATIENT INFORMATION

Last Name _____ **First Name** _____ **Middle Name** _____ **Maiden** _____

Date of Birth _____/_____/_____ **Birth City, State** _____ **Sex: Male**_____ **Female**_____ **SSN** _____-_____-_____

Primary Phone Number (_____)_____ **Secondary Phone Number** (_____)_____ **Work Phone Number** (_____)_____

Mailing Address _____ **City, State** _____ **Zip Code** _____

Physical Location of Home (if different than mailing) _____ **City, State** _____ **Zip Code** _____

Email Address _____ **Do you have internet access? _____YES _____NO**
If Yes, where? _____

Marital Status: ____ Married ____Single ____Divorced ____ Widow(er)

Ethnicity: ____ Hispanic or Latino ____Non-Hispanic or Latino ____Decline to Answer

Race: ____ Amer. Indian/Alaska Native ____African Amer./Black ____ Asian ____ Native Hawaiian/Pacific Islander

____ Caucasian/White

Primary Language: ____ English _____ Other:_____

Are you a migrant worker: _____YES _____NO **Are you currently Homeless: _____YES _____NO**

EMPLOYER INFORMATION

Are you an employee of CPN? _____YES _____NO

Employer Name _____ **Address** _____ **Phone Number** _____

Spouse's Employer Name _____ **Address** _____ **Phone Number** _____

Last Name: _____ First Name: _____ Date of Birth: _____Chart #_____

TRIBAL AFFILIATION

Are you a member/citizen of a federally recognized tribe? _____YES _____NO

Do you have a Tribal ID or Certification of Indian Blood Card (CDIB)? _____YES _____NO

If yes, what is the name of the federally recognized tribe? _____

EMERGENCY CONTACT / NEXT OF KIN

EMERGENCY CONTACT:

Last Name	**First Name**	**Relationship**	**Phone Number**
Mailing Address		**City, State**	**Zip Code**

NEXT OF KIN:

Last Name	**First Name**	**Relationship**	**Phone Number**
Mailing Address		**City, State**	**Zip Code**

MILITARY SERVICE

Are you currently or have you in the past served in the United States military? _____YES _____NO

If yes, which branch? ____ Air Force ____Army___ Coast Guard ____Marine Corps___ Navy___ Nat. Guard

____ Other: _____

Dates of Service: _____ Are you currently active duty? _____YES _____NO

MEDICAL INSURANCE

Do you have medical insurance (including Medicare, Medicaid, or Private Insurance)? _____YES _____NO

If yes, please complete the attached *Private Insurance form.*

If no, patients will be required to meet with the Citizen Potawatomi Nation Health Services Benefits Coordinator prior to or at the date of the patient's first clinic visit.

Failure to provide medical insurance (Medicare, Medicaid, private insurance, etc.) could result in suspension or denial of services. Funds collected from third party resources are used improve and expand medical services at Citizen Potawatomi Nation. Native Americans are not billed for any remaining balances, following insurance payment.

Last Name: _____ First Name: _____ Date of Birth: _____Chart #_____

CLINIC LOCATION PREFERENCE / SERVICES REQUESTED

PREFERRED CLINIC LOCATION:

East Clinic: _____
2307 E. Gordon Cooper Drive
Shawnee, OK 74804
(405) 273-5236

West Clinic: _____
781 Grand Casino Blvd.
Shawnee, OK 74804
(405) 964-5770

Is there a specific need or reason for which you would like to be seen?

_____

CLINICAL SERVICES REQUESTED:

____ Medical **____ Dental*** **____ Optometry** **____ Behavioral Health***

*** Please note that these services require an additional application. Our team is happy to provide these forms to you upon request.**

Chart #_____

CITIZEN POTAWATOMI NATION HEALTH SERVICES
INSURANCE DISCLOSURE FORM

PART I-PATIENT INFORMATION

_____ **Last Name**

_____ **First Name**

_____ **Middle Name**

_____ **Maiden**

_____/_____/_____ **Date of Birth**

_____ **Social Security Number**

Sex: Male_____ Female_____

(_____)_____ **Primary Phone Number**

(_____)_____ **Secondary Phone Number**

(_____)_____ **Work Phone Number**

_____ **Mailing Address**

_____ **City, State**

_____ **Zip Code**

Race: ____ Amer. Indian/Alaska Native ____African Amer./Black ____ Asian ____ Native Hawaiian/Pacific Islander

____ Caucasian/White

If you are Native, please specify the tribe in which you are enrolled: _____

Do you have Medicare? _____Yes _____No If yes, what is the Medicare ID# _____

Do you have Medicaid? _____Yes _____No If yes, what is the Medicaid ID# _____

Do you have Private Insurance? ____Yes ____No [Vision Benefits? ____Yes ____No Dental Benefits? ____Yes ____No]

Please verify the information above is correct. If the information provided is accurate, sign and date the form below.
If you are insured, please provide additional information on Part II (located on the back page).

Disclaimer: If you or your dependent have health insurance coverage and fail to advise CPNHS of the coverage or you are eligible for coverage but refuse to apply, CPNHS may impose sanctions involving suspension or withdrawal of your eligibility to receive services within our health system.

_____ _____
Patient Signature **Date**

_____ _____
Parent/Guardian Signature **Date**

_____
Relationship to Patient

PART II- PRIVATE INSURANCE INFORMATION

Note: In Part II, provide information on the policy holder of the patient's health insurance policy.

Last Name of Policyholder _____ **First Name of Policyholder** _____ **Relationship to Patient** _____

Date of Birth _____/_____/_____ **Social Security Number** _____ **Phone Number** (_____)_____

Mailing Address _____ **City, State** _____ **Zip Code** _____

Name of Insurance Company _____ **Effective Date** _____

Policyholder's Employer _____ **Phone Number** (_____)_____

Policyholder Employment Status: ____Full Time ____Part Time ____Retired ____Furloughed ____Laid-off

Provide information below on other family members covered by this insurance policy:

Patient's Name	Relationship to Policyholder	Date of Birth	Chart # (if known)	Effective Date

Please provide FRONT and BACK copies of insurance cards. Make sure application is complete and all necessary documents are attached.

Patient Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

Relationship to Patient _____

CPN HEALTH SERVICES
ADULT NEW PATIENT QUESTIONNAIRE

Please fill out this questionnaire fully and to the best of your knowledge. Your answers are protected health information and are closely guarded to protect your privacy and the confidentiality of your patient-provider relationship.

Name: _____ Date: _____

Date of Birth: ____/____/_____ Sex: ___ Male ___ Female Ht:____ Wt:___

Past Medical History

Circle if you have had any of the following medical conditions:

Allergy to Anesthesia
Anemia/Blood Disorder
Arthritis - Type: _____
Blood Vessel Disorder
Blurred Vision
Breathing Problems
Cancer - Type: _____
COPD/Asthma
Depression
Diabetes
Drug/Alcohol Addiction
Ears, Nose, Throat problems
Gastro-intestinal Reflux
Heart Disease
Heart Failure
High Blood Pressure
HIV/AIDS
Incontinence/Urinary Problems
Kidney disease/Stones
Liver problems/Hepatitis
Neurological problems
Osteoporosis
Prostate Problems
Seizures/Frequent Headaches
Sleep Apnea/CPAP
Stomach Ulcers/Bloody Stools
Stroke/Blood Clots
Thyroid Disease
Tuberculosis
Other: _____

Past Surgical History

Please indicate all previous surgeries you have had (Colonoscopy, EGD, Tubal, Vasectomy, Joint Replacement, Hysterectomy, etc):

YEAR	PROCEDURE	SURGEON	LOCATION

Immunizations

When was your last Flu shot_____ Pneumonia Vaccine_____ Tetanus/Diphtheria_____
If patient is less than 18 years old: Are Immunizations up to date:_____

(PLACE LABEL HERE)

Name: _____ Date of Birth _____/_____/_____

Current Medications
Please list all prescriptions including any over-the-counter medications. Also list any herbal medications/supplements. (May use additional paper if needed)

NAME	DOSE	FREQUENCY		NAME	DOSE	FREQUENCY

Allergies to medications, foods, latex, or other substances:

Name the medication/item & indicate the **reaction** you had:

_____

_____

Females Only:
Pregnant: Yes No Planning If yes, what is due date_____
When was your Last Menstrual Period _____ Pap Smear_____ Mammogram_____

Family Medical History
Circle if any of the following exist in your family or relatives:

Arthritis
Asthma
Bleeding Problems
Cancer Type: _____
Diabetes
Heart Disease
High Blood Pressure
Kidney Failure
Mental Illness/Depression
Neurological problems
Osteoporosis
Seizures
Stroke

Social History
Please **circle** all that apply:
Marital Status: Married Divorced Widowed Single Reside with significant other

Tobacco: Never used Former smoker Current Smoker Chewing Tobacco Vape
Alcohol: Never Occasionally Frequently

Non-Prescription Drug Use: Have you ever injected drugs into your veins? ____ Do you use any illegal drugs? ____

Do you have a living will indicating your advanced directive for health care? _____
Do you want information about a living will? _____

_____ _____
Provider Signature Date

(PLACE LABEL HERE)

CITIZEN POTAWATOMI NATION HEALTH SERVICES

PATIENT CONSENT
FOR
USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing these consents, I understand that it is good for one year from date of signature. I may revoke this consent at any time by submitting a written revocation notice. I can not hold the CPNHS liable for use and disclosures made prior to my revocation. If I do not sign this consent statement, the CPNHS may decline to treat me.

I, _____, freely give my consent to the Citizen Potawatomi Health Services (CPNHS) to disclose protected health information about me in order to facilitate my treatment, perform billing and payment functions, and accomplish other healthcare operations. I have been given the opportunity to read and have explained to me the CPNHS Notice of Privacy Practices prior to signing this consent. I understand that the CPNHS has the right to revise its Notice of Privacy Practices, and that I can obtain a copy of the current Notice by sending a written request to the Privacy Officer, 2307 S. Gordon Cooper Dr., Shawnee, OK 74801.

I freely give consent to CPNHS employees to call my home or other designated locations and to leave messages on voice mail or in person concerning items and topics which might assist the CPNHS performing treatment, payment, and other healthcare operations. I include in this consent statement, appointment reminders and calls pertaining to my care and treatment, laboratory, and X-ray results. I give consent to CPNHS to mail items to my home or other addresses designated by me, items dealing with my treatment, payment for services rendered to me, and other healthcare operations as long as they are marked "Confidential" and addressed to me.

I give consent to the CPNHS to notify me through home and/or mobile voice mail, mobile text messages or by email designated by me which will assist the CPNHS in performing treatment, payment and other healthcare operations.

I understand that I have the right to issue restrictions on the way the CPNHS uses and discloses my protected health information and I know that the CPNHS is not required to agree to my restrictions. If it does agree, it is bound by the agreement to observe my restrictions.

By signing this form, I give my consent to the CPNHS to use and disclose my protected health information for the purposes of treating me, for obtaining payment for services rendered to me, and for conducting other healthcare operations related to my care.

_____/_____ _____ _____

Signature of Patient or Personal Representative/Date | Printed Name of Patient | Patient's Date of Birth

Print name of signer if different than patient: _____ Check one: Father ____, Mother ____,

Legal Guardian ____, Other with Minor Consent on file ___. Relationship to patient: _____

CONSENT FOR TREATMENT AND ASSIGNMENT OF BENEFITS

I voluntarily submit to the treatment and diagnostic testing deemed necessary by my CPNHS provider for me or the minor child named below to whom I am parent, medical surrogate, or personal representative. I understand that treatment may include, but not limited to testing for diseases such as HIV, hepatitis, syphilis, or gonorrhea.

I authorize payment of insurance benefits to be paid directly to CPNHS for services provided by CPNHS providers, and by executing the Patient Consent for Use and Disclosure of PHI above, I give consent for the use and disclosure of private health information for the purposes of securing payment of benefits. A photocopy of this document has the same validity and full force as the original.

_____/_____ _____ _____

Signature of Patient or Personal Representative/Date | Printed Name of Patient | Patient's Date of Birth

CPNHS Limited Confidentiality Clause

CPNHS Special notice for CPN Employees and patients who are related to or in some other way affiliated with a/an CPN Employee(s):

While CPNHS strives to maintain the upmost confidentiality and minimize conflicts of interest when it comes to all medical and behavioral health concerns; there are times when CPNHS treatment providers and employees other than your primary treatment provider will be involved in your medical care and/or have access to your medical records including behavioral health notes. There may be situations where your information could be viewed and/or acted upon by someone you are related to or otherwise affiliated with. This is especially true if you are a CPN tribal member due to CPNHS Governing Board's dual mandate of serving CPN tribal members as patients and employing qualified CPN tribal members in medical professional and support staff roles. This could potentially present conflicts of interest for you and/or the person viewing/acting on your information. There may be situations where providers and staff will need to act on that information to provide timely medical standard of care to a patient who is a family member or co-worker. There may be times where acting is not felt to be appropriate by the provider and assistance from another colleague is requested. There may be situations where the conflict of interest is large enough that it prohibits long term continuation of care with your provider or accessibility to certain CPN clinics. If a conflict such as this arises you will be provided with appropriate referral options. If you have questions or concerns about this please bring those up to your provider at the beginning of your appointment. By signing below you indicate your understanding of the limits of confidentiality.

_____/_____ _____ _____

Signature of Patient or Personal Representative/Date Printed Name of Patient Patient's Date of Birth

Print name of signer if different than patient: _____ Check one: Father ____, Mother ____,

Legal Guardian ____, Other with Minor Consent on file ___. Relationship to patient: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES NOTICE RECEIPT

Official use: Chart # _____

I have received and read a copy of the Citizen Potawatomi Nation Health Services ***Privacy Practices Notice*** outlining how my personal health information will be used and safeguarded, and my rights regarding the protection of my personal data.

I understand that the CPNHS *Privacy Practices Notice* was provided to me in accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996, and that if I have any questions about the content of the *Notice* I can contact the CPNHS Privacy Officer by mail at 2307 S. Gordon Cooper Dr, Shawnee, Ok 74801.

I have been told that if I decline to sign this acknowledgement, my refusal will have no bearing on my eligibility for treatment at the Citizen Potawatomi Nation Health Services facilities. I will continue to be treated based on my eligibility for benefits extended by the CPNHS.

_____, _____-_____-_____
Print Name of Patient **Date of Birth**

_____/ _____
Signature of Patient, Parent, Legal Guardian Date

Print signers name if other than self: _____

Check one: Father ____, Mother ____, Legal Guardian ____,

Other with Minor Consent on file __ ___. Relationship to patient _____

1st Endorsement

Patient declined to sign the Acknowledgement of Privacy Practices Notice Receipt.

_____/ _____
CPNHS Employee Date

CITIZEN POTAWATOMI NATION HEALTH SERVICES (CPNHS)
CPN EAST CLINIC and CPN WEST CLINIC
PRIVACY PRACTICES NOTICE
Effective August 10, 2011

The Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 require that you, our patient, be informed about how your protected health information (PHI) is used and disclosed by the CPNHS, and how you can get access to your individually identifiable health information (IIHI). PLEASE READ THIS NOTICE CAREFULLY!

THE CPNHS/CPN WEST COMMITMENT TO PROTECTING YOUR PRIVACY

CPNHS employees protect the privacy of your IIHI. In the normal course of providing your care we create records regarding you and the nature of your visits. We are required by law and bound by professional ethics to keep information about you confidential and private. This statement describes our obligations to you and the privacy practices we employ to protect your IIHI. We are ethically and legally bound to observe the terms of this notice or of subsequent Privacy Practices Notices which might replace it. We reserve the right to change this Privacy Practices Notice and any revision or amendment will be applicable to all records we create or maintain concerning you in the future. A copy of the current Notice will be posted in the reception area and you are welcome to a copy of your own. **If you have questions about this Notice, please contact the Privacy Officer by mail at 2307 S. Gordon Cooper Dr., Shawnee, OK 74801.**

CPNHS/CPN WEST USES AND DISCLOSURES OF YOUR IIHI

TREATMENT. Information gained from examinations and diagnostic tests will be used to diagnose and treat you. For example, we may ask you to have an X-ray made, and we may use the results to diagnose your injury or illness. We may disclose this information to others who are involved in your care and treatment including family members.

PAYMENT. We may use and disclose information about you in order to bill and collect payments from public and private healthcare insurers and payers for services rendered to you. For example, if you have health insurance, we may exchange information about your visits with your insurer in order to obtain reimbursement from them.

HEALTHCARE OPERATIONS. We may use and disclose data concerning you during the routine performance of functions related to our practice of medicine, dentistry, and public health activities. These functions include the peer review and quality assurance programs, practice management activities, financial management actions, and case management processes. For example, we may use information about you to call and remind you of an appointment, and we may discuss your IIHI to establish treatment plans and therapy options.

SPECIAL CIRCUMSTANCES INVOLVING YOUR IIHI

Under a limited number of specific circumstances, we may use or disclose your protected health information without your consent. These circumstances include:

PUBLIC HEALTH RISKS. The CPNHS may disclose your IIHI to public health authorities allowed by law to have the information for (a) maintaining vital records; (b) reporting cases of abuse, neglect, and abandonment; (c) preventing or controlling disease, injury, or disability; (d) notifying individuals of potential exposure to a communicable disease; (e) reporting adverse reactions to drugs or medical devices; (f) communicating with your employer concerning workplace-related illness or medical surveillance.

HEALTH OVERSIGHT ACTIVITIES. The CPNHS may disclose your IIHI to a health oversight agency with a legal right to have it. Oversight activities include (a) investigations; (b) inspections; (c) audits; (d) licensure and disciplinary actions; (e) civil, administrative, and criminal proceedings; and (f) activities necessary for monitoring government-sponsored programs, and (g) compliance with civil rights laws.

LAWSUITS AND SIMILAR PROCEEDINGS. The CPNHS may use and disclose your IIHI in response to court or administrative orders and subpoenas. We will always try to notify you of the request so that you can take whatever actions you deem appropriate. We may disclose your IIHI if asked to do so by a law enforcement official in connection with (a) a crime victim; (b) a death resulting from criminal conduct; (c) criminal conduct occurring at the CPNHS/CPN West facility; (d) identifying or locating a suspect, material witness, fugitive, or missing person; or (e) in an emergency to report a crime.

THREATS TO HEALTH OR SAFETY. The CPNHS may disclose or use your IIHI to reduce or prevent threats to your health or safety or the health and safety of another person or the general public.

MILITARY OR NATIONAL SECURITY. The CPNHS may disclose your IIHI if you are a member of the U.S. or foreign military forces if asked to do so by the appropriate authorities. We may also divulge your IIHI to federal officials for reasons related to the security of the nation, the protection of the President or other officials or foreign heads of state.

INCARCERATION. The CPNHS may disclose your IIHI to corrections officials if you are incarcerated (a) to assist the institution to provide health services to you; (b) for the safety of the institution; and to (c) protect the health and safety of other individuals in the institution.

WORKERS' COMPENSATION. The CPNHS may disclose IIHI to workers' compensation officials.

YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI the CPNHS produces or maintains about you:

CONFIDENTIAL COMMUNICATION. You may request the CPNHS communicate with you in a particular manner or a specific location. For example, you may ask that we contact you at work rather than at home. You needn't give a reason for your request, and we will give you a CPNHS Form 700-9b for expressing your wishes. We will honor reasonable requests but you may have to pay if there are costs associated with your request.

RESTRICTIONS. You may request the CPNHS restrict the use or disclosure of your IIHI for treatment, payment, or other operations. For example, you can request that your IIHI not be released to certain individuals. Your request must be in writing and you can use the CPNHS Form 700-9b or a letter for your request. **We do not have to agree with your request**, but if we do agree, we will abide by our agreement.

RECORD COPIES AND INSPECTION. You have the right to view and obtain copies of your IIHI **except for psychotherapy notes.** Your request must be written and we ask that you use the CPNHS Form 700-4 to request a review of your records and the Form 700-3 to request copies. If we deny you access, you can ask for a review of the denial by a licensed healthcare professional of our choosing.

AMEND RECORDS. You may ask the CPNHS to amend your IIHI if you believe it is incorrect or incomplete. You must request the amendment in writing and we ask that you use the CPNHS Form 700-5 for this purpose. We may deny your request to amend your record if (a) the record is accurate and complete; (b) we don't have the records you want amended; (c) the record you want amended is not available for your review (i.e. psychotherapy notes); or (d) the record was not created by the CPNHS (unless the author is no longer available to amend the record).

DISCLOSURE EXPLANATION. You have the right to an accounting of certain non-routine disclosures the CPNHS has made of your IIHI for purposes other than treatment, payment, or other related operations. We are not required to document uses of your IIHI for routine patient care purposes. You must submit your request in writing and specify a time period not longer than six (6) years from the date of the disclosure and not earlier that April 14, 2003. One accounting is provided at no cost but we may charge you for additional requests during any 12-month period. We will inform you of the cost before we comply with your request and you may authorize us to continue or you may withdraw the request.

PERSONAL NOTICE. You have the right to a personal copy of this Notice. Ask the receptionist in the central reception area for a copy and it will be provided at no cost.

COMPLAINT. If you believe your privacy rights have been violated, you may complain to the Director, CPNHS or to the Secretary of the Department of Health and Human Services. Complaints to the CPNHS must be submitted in writing to the Privacy Officer, 2307 S. Gordon Cooper Drive, Shawnee, OK 74801. **You will not be penalized for filing a complaint.**

AUTHORIZATION. The CPNHS will obtain your written authorization for uses and disclosures of your IIHI which are not addressed by this Notice or permitted by law. You can revoke any authorization you give us at any time by submitting the revocation in writing to the CPNHS Privacy Officer.