First Flight Health Centers™

1323 West 3rd Street Dayton, Ohio 45402-6714

Release of Information

IMPORTANT: Charges for this request may apply. Allow 5 business days for processing. Form must be HIPAA compliant and will not be processed if invalid.

Physician/Site Authorized to **Release** Information:

Name:_____

Address:_____

_____

Phone/Fax:_____

Physician/Site/Person Authorized to **Receive** Information:

Name:_____

Address:_____

_____

Phone/Fax:_____

For the purpose of: ☐ Self/Transfer of Care (charge may apply) ☐ Continuity of Care/Treatment ☐ Insurance Claim

☐ Legal Matter (specify) _____ ☐ Other (specify) _____

Patient Name (include previous name): _____

Date of Birth:_____ Phone:_____

Address:_____ Apt #:_____

City/State/Zip:_____

Format: ☐ Electronic Copy ☐ Paper Copy

☐ Fax ☐ Pick up ☐ Mail ☐ Encrypted Email: _____

Information for release:

☐ **Medical:** **Date(s) of Service:**_____

☐ Demographic Sheet ☐ Chart Notes ☐ Laboratory Reports ☐ ER Reports

☐ Immunizations ☐ Consultations ☐ Radiology Reports ☐ Hospital Reports

☐ Billing Records ☐ Other (specify)_____

☐ **Dental:** **Date(s) of Service:**_____

☐ Treatment Records ☐ Radiology Images ☐ Billing Records

☐ **Behavioral Health:** **Date(s) of Service:**_____

Federal Regulation Code 42, part 2 prohibits unauthorized disclosure of these records

☐ Psychiatric Notes ☐ Psychotherapy Notes

☐ Psychiatric Assessment ☐ Behavioral Health Diagnostic Assessment

☐ Other (specify)_____

Signature:_____(**MUST** Sign for Behavioral Health)

I hereby grant my permission for the release or review of the above information concerning my healthcare. I understand this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and that by signing below, I am authorizing the release of this information. I understand that the information I authorize a person or entity to receive may be re-disclosed unless it is information pertaining to substance use disorder treatment which is protected through the 42 CFR part 2 and prohibits re-disclosure. I understand that this authorization is voluntary and that I may refuse to sign. My refusal to sign will not affect my ability to obtain treatment. I understand that this authorization may be withdrawn at anytime in writing (see Notice of Privacy). This authorization will be effective for sixty (60) days after I sign and date the form below, unless I specify an earlier expiration date in the provided space:_____

_____ _____ _____

(Date) **(Patient/Guardian/Representative Signature)** (Witness)

If above signature is not the patient, please print name: _____

☐ Minor ☐ HCPOA ☐ Executor ☐ Guardianship ☐ Deceased ☐ Other (specify)_____

Office Use ONLY

Copy of ROI Given to Patient: ☐ Yes ☐ No Date Completed:_____

Note: _____

First Flight Health Centers™

MEDICAL AND DENTAL HISTORY

Patient Name: _____ DOB: _____ Sex: ___ Name of Physician_____

When was your last physical? _____ Are your immunizations up to date? ☐ Yes ☐ No

Are you now under the care of a physician? ☐ Yes ☐ No

If yes, for what reason? _____

Are you presently taking any medications/drugs/pills? ☐ Yes ☐ No Please list: _____

_____

Are you allergic (or have an adverse reaction) to?
☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Aspirin ☐ None
☐ Other ☐ Other Antibiotic Please describe: _____

Are you sensitive or allergic to latex? (i.e. Experienced itching, rash or wheezing after using latex gloves or handling a balloon)
☐ Yes ☐ No If yes, please explain: _____

Have you had any unusual or unexplained reactions during a surgical procedure? ☐ Yes ☐ No
If yes, please explain: _____

Do you have, or have you had any of the following: (Yes or No)

Yes	No		Yes	No		Yes	No	
☐	☐	Abnormal Blood Pressure	☐	☐	Epilepsy	☐	☐	Osteoporosis
☐	☐	Alcohol Addiction	☐	☐	Fainting Spells	☐	☐	Prolonged Bleeding
☐	☐	Anemia	☐	☐	Glaucoma	☐	☐	Prosthetic Implants
☐	☐	Anorexia	☐	☐	Hearing Impaired	☐	☐	Psychiatric Care
☐	☐	Arthritis/Rheumatism	☐	☐	Heart Disease/Surgery	☐	☐	Radiation Therapy
☐	☐	Artificial Heart Valve	☐	☐	Heart Murmur	☐	☐	Removal of Spleen
☐	☐	Artificial Joint	☐	☐	Heart Pace Maker	☐	☐	Rheumatic Fever
☐	☐	Asthma	☐	☐	Hemophilia	☐	☐	Rheumatic Heart Disease
☐	☐	Bulimia	☐	☐	Hepatitis ☐A ☐B ☐C	☐	☐	Sickle Cell Disease
☐	☐	Cancer	☐	☐	HIV Positive / AIDS	☐	☐	Sinus Trouble
☐	☐	Chemical Dependency	☐	☐	Kidney Problems	☐	☐	Stroke
☐	☐	Chemotherapy	☐	☐	Learning Disability	☐	☐	Thyroid Problems
☐	☐	Congenital Heart Disease	☐	☐	Liver Disease	☐	☐	Tuberculosis
☐	☐	Cortisone Medicine	☐	☐	Lung Disease	☐	☐	Tumors
☐	☐	Diabetes	☐	☐	Mitral Valve Prolapse	☐	☐	Ulcers
☐	☐	Recreational Drugs	☐	☐	Neurological Disorders	☐	☐	Venereal Disease
☐	☐	Emphysema	☐	☐	Organ Transplant	☐	☐	Do you clench or grind your teeth
☐	☐	Do you have TMJ	☐	☐	Do you have frequent headaches			
☐	☐	Have you ever had prolonged bleeding following extractions						

Have you had any other serious illness, hospitalization or accident? ☐ Yes ☐ No
If yes, please explain: _____

Do you currently smoke or use the following tobacco products? ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chew ☐ None

Have you used tobacco products in the past? ☐ Yes ☐ No If yes, how long ago? _____

WOMEN: Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Patient/Parent/Guardian: _____ Date: _____

Relationship: _____

Dentist: _____ Date: _____

First Flight Health Centers™

PATIENT INFORMATION REGISTRATION FORM: Complete all sections

PATIENT INFORMATION:

Last name	First Name	MI	Nickname	Social Security #	Birthdate	Birth Sex

BILLING ADDRESS of Patient or Responsible Party	City	State	Zip

Home Phone (_____)-_____-_____ Cell Phone (_____)-_____-_____ Other (_____)-_____-_____

FFHC has my permission to leave a message on my contact phone numbers/answering machine or cell phone voicemail regarding my healthcare needs. ____Yes ____No _____initial

E-Mail Address: **Decline to Provide** ☐

RESPONSIBLE PARTY (Required for patients under 18 or whenever the guarantor is not the patient):

Last Name	First name	MI	Social Security #	Birth Date	Relationship

INSURANCE INFORMATION (Please present ALL Patient Insurance Cards and a Picture ID to the receptionist):

Primary Insurance	Policy Holder	Date of Birth	Effective	Policy #	Relationship
Secondary Insurance	Policy Holder	Date of Birth	Effective	Policy #	Relationship

INFORMATION FOR STATISTICAL REPORTING ONLY: Please ✓ all that apply TO THE PATIENT:

Race: _White __Black/African American __Asian __Asian Indian __American Indian/Alaska Native __Native Hawaiian/Pacific Islander __Chinese __Filipino __Guamanian/Chamorro __Japanese __Korean __Vietnamese __Samoan __Other Asian __More than one Race

Ethnicity: Are You Latino/Hispanic __YES __NO __ Mexican __ Mexican American __ Chicano/a __ Cuban __ Puerto Rican

Preferred language: __ English __ Spanish __ French __ German __ Russian __ Sign Language __ Other:_____

Marital Status: __ Single __Married __Widowed __Legally Separated __Divorced __ Life Partner __Other:_____

If you are a: __ Veteran __ Smoker **Housing**: __Doubling Up __Transitional __Shelter __Street

Occupation: __Retired __Disabled __Unemployed __Student __Decline to answer __Employed (list below what you do)
If employed tell us what you do: _____

What **Advanced Directives** do you have: __ Living Will __ Durable Power of Attorney __ None __Decline to answer
If Yes, please specify who & their relation to you _____

Legal Guardian: __ Yes, Name_____ __ None

Health Care Proxy: __ Yes, Name_____ __ None

Primary Caregiver: __ None/Self __ Yes If yes, Who: _____ Relationship: _____

I grant FFHC staff consent to talk to the following people about my health information:

Name	Relationship	Phone Number
Name	Relationship	Phone Number

I understand that FFHC will not discuss my medical care or billing information with anyone not listed above. I understand that this consent supersedes any other consent that may have been signed. I have the right to revoke this consent by notifying FFHC in writing, except to the extent that FFHC has taken action in reliance on my consent.
I understand that it is my responsibility to provide complete and accurate information on this form. I understand that failure to provide correct information may result in my being responsible for full charges for services provided.
I understand the No Show Policy provided to me and agree it is my responsibiliy to follow it.

Patient Name (Printed)	Signature of Patient/Responsible Party	Date

First Flight Health Centers™

I. GENERAL CONSENT FOR TREATMENT

A. I, the undersigned, am the patient (or the Patient's duly authorized representative) and do hereby voluntarily consent to and AUTHORIZE CARE, INCLUDING NURSING CARE AND ALL DIAGNOSTIC AND THERAPUTIC TREATMENTS CONSIDERED NECESSARY OR ADVISABLE IN THE JUDGMENT OF THE PHYSICIAN, AND/OR HIS/HER ASSISTANTS OR DESIGNEES.

B. I consent to the performance of diagnostic testing, including the drawing of blood, in the event that a First Flight Health Centers (FFHC) staff member is exposed to any of my body fluids. This includes HIV/AIDS testing.

II. RELEASE OF INFORMATION CONSENT

A. I authorize FFHC, by this written release, to furnish information from the patient's medical record to its agents, or any insurers, compensation carrier, healthcare facility, welfare agency or any healthcare provider for reasons of financial assistance or continuity of medical care.

B. I do not authorize disclosure of the following information (list any exclusions, for example, information regarding drug or alcohol treatment, psychiatric treatment, AIDS, AIDS related condition, HIV testing, or diagnosis and treatment of HIV):

_____

C. I authorize FFHC to access medication records from my pharmacy as needed to provide continuity of care.

III. HIPAA PRIVACY CONSENT

A. I consent to First Flight Health Centers (FFHC) using and disclosing my protected health information to carry out treatment, payment, or health care operations.

B. I understand and have been provided with a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent. I understand that FFHC reserves the right to change their notice and information practices and that I may obtain a revised copy of the notice by requesting one from the health center.

C. I understand that calls to and from FFHC may be recorded for quality and training purposes.

D. We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We and other healthcare providers may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying FFHC Medical Records.

IV. TITLE X SERVICES CONFIDENTIALITY CONSENT

A. In the event that I receive Reproductive Health and Wellness/Family Planning services at FFHC, I am aware that such services will be provided in a way that ensures my client confidentiality.

B. I understand that services are provided on a voluntary basis without subjecting individuals to any coercion to accept services or to employ, or not to employ, any particular methods of family planning. Services are not made a prerequisite to eligibility for, or receipt of, any other services, assistance from or participation in any other program with FFHC.

C. I understand that information obtained by staff regarding these services may not be disclosed without my documented consent, except as required by law or as may be necessary to provide services, with appropriate safeguards for confidentiality.

D. I understand that I will be informed of any potential for disclosure of my confidential health information to policyholders where the policyholder is someone other than myself.

My signature, or that of my authorized representative, indicates that I have read, understand and agree with the above conditions and I have provided accurate information.

Patient Name Printed	Patient DOB	Date Signed

Signature of Patient or Legal Representative or Agent	Relationship	Signature of Witness	Date

PATIENT RIGHTS AND RESPONSIBILITIES

As a patient of First Flight Health Centers you have the following rights:

- To be treated with respect, compassion and consideration without regard to race, gender or ability to pay
- To quality heath care
- To a timely response to requests for health care services
- To know the name and qualifications of staff members providing care
- To privacy of your medical and financial records
- To make informed decisions regarding your medical treatment including the right to refuse treatment
- To request a consultation
- To see and obtain a copy of your medical records
- To request financial information regarding your account
- To designate a guardian or Power of Attorney (POA) to act on your behalf
- To an interpreter

As a patient of First Flight Health Centers you have the following responsibilities:

- To maintain healthy habits
- To be respectful to all physicians, nurse practitioners, and staff members.
- To provide complete and accurate information to your physician or nurse practitioner.
- To provide a complete list of all medications you are currently taking including dosage
- To adhere to all treatment plans including correct use of prescriptions
- To contact the office for an appointment when you pick up the last refill on your prescription
- To arrive for all appointments on time and to contact the office at least 24 hours in advance if you are unable to make it
- To keep all appointments scheduled for ancillary tests or to a consulting physician
- To provide us with current and accurate information regarding your insurance carrier
- To notify your insurance carrier of any change in primary care provider
- To provide us with a copy of all insurance cards
- To complete a sliding fee scale application and to provide documentation of household income
- To notify us of any change in your income status as it relates to your sliding scale status.
- To pay all copayments and sliding scale nominal fees at time of service
- To complete a patient registration form, sliding fee scale application and associated signatures on an annual basis.
- To notify us of any change in insurance, address, telephone number, marital status

I, as a patient of the FIRST FLIGHT HEALTH CENTERS, agree to the above patient rights and responsibilities.

_____ _____

Patient Name Date

_____ _____

Signature of Patient or Guardian (if patient is a minor) Date

First Flight Health Centers™

WELCOME TO OUR PRACTICE

Scheduling Line: 937-461-6869 M-F 7:30 am to 5:30 pm

Please use this number to make all appointments. Also use this to cancel or reschedule any appointments.

First Flight Health Centers (FFHC) is a nonprofit organization founded in 2007 to improve access to high-quality, affordable primary health care in the region. We currently operate five locations: Alex Central Health Center, Chambersburg Health Center, Charles Drew Health Center, Corwin Nixon Health Center, and East Dayton Health Center.

Our Mission: Improving lives by providing quality primary and preventative healthcare services to those in need, regardless of ability to pay.

In order to assure that we submit the charges for your services to the correct insurance carrier, we ask that you present your insurance card and picture ID at each visit. If you are unsure which card is correct, please bring all cards and our staff members will assist you. **We do not accept Bureau of Workers Compensation claims.**

All patients are asked to complete a Sliding Fee Discount Application to assist us with determining if you are eligible for a fee discount and to meet our Federal Funding Guidelines.

You will be assigned a physician or nurse practitioner that will be your primary provider for every visit. It is our goal to be the Patient Centered Medical Home (PCMH) for all of your health care needs – this includes your urgent needs. Please contact us first for your urgent health care needs as they come up. If your assigned provider is unavailable, one of our other providers may be able to take care of your needs for that day. To reach a provider after hours, please call the center and the message will provide instructions for reaching the provider on-call.

We may at times have health professional students in our practice participating in your care. If you would prefer that students not participate in your care, please inform a member of our staff.
New patients may not request prescriptions for controlled substances on their first visit and these medications will not be routinely refilled over the phone.

Our health care providers do not provide chronic pain management; but may refer you to a health care provider specializing in these medical problems.

When you arrive for a visit, tell the medical assistant exactly why you need to see your physician or nurse practitioner and what medication refills you will need. Please bring all medications with you to your visit. When calling in to receive medication refills, it can take between twenty-four (24) and seventy-two (72) hours to complete the entire process.

Thank you for choosing First Flight Health Centers.
We look forward to becoming your Patient Centered Medical Home.

First Flight Health Centers™

NOTICE OF PRIVACY PRACTICE

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

First Flight Health Centers (FFHC) will create a medical record for you. The medical record has information about your medical history, the tests you had, the care you received, and how you responded. We also have billing records. We are required by law to make sure your medical information is kept private. We are also required to give you this Notice. We are required to tell you how we use and share your medical information; verbal, written or electronically, and tell you what your rights are. We will ask for your signature to verify that you have received a copy of this notice.

1. Uses and Disclosure for Your Health Information

A. Situations information can be shared without written agreement. Your consent allows us to treat you. It also allows us to share your personal information in certain situations. This is a list of situations we can share your information.

Treatment Purposes

- Others who would need to know about your health problems to make sure you are given complete and safe care. This could include other doctors, nurses, health students/residents/interns, hospitals, equipment providers, etc.
  - For example, if you are admitted to a hospital we could share your information with them to help with your care.
  - If you are referred to a specialist we may share part of your information to help you get more complete care.
- When you consent, some information will be shared with close friends or family who help with your care. If you are not able to consent, we will do what we believe is best for you.

Payment for Care

- To allow us to receive payment for the care you have been given.
  - For example, information may be shared with your insurance company. This could happen after the care has been given. It could happen before care is given if the insurance company requires prior approval.
- Information may also be released to someone who is helping you pay for your care.

Healthcare Tasks

- Improving the healthcare given to our patients. For example:
  - To assess the care given to you and how you responded.
  - To help train doctors or other healthcare workers.
  - To review and improve on the care we provide.
- To let health oversight agencies make sure we are following the rules of programs like Medicare and Medicaid.
- To call or send appointment reminders to you.
- To let you know about other treatments and services available to you.
- To give you marketing materials during a face-to-face visit or when we tell you about our products and services.
  - You can opt-out of receiving marketing or fund-raising.
  - You must give us written permission to provide marketing information to a third-party company.

Public Health

- To help prevent or control disease, injury or disability. This would include notifying you if you have been exposed to a disease. We would notify you if you may be at risk for contracting or spreading a disease or condition.
- In most cases, information concerning tests or treatments for HIV or AIDS will not be released without your permission.
- To report your reactions (like an allergy) to medications or problems with products. To notify you for any product recalls.
- To report births, deaths, child abuse or neglect and domestic violence.

Legal Reasons

- When we are required by law to tell the police, other law enforcers or by subpoena or grand jury.
  - Steps will be taken to inform you of any subpoena if you did not request it.
- When we must respond to a legal order or lawful process.
- Report certain injuries, such as gunshot wounds, burns or injuries to perpetrators of crime.
- Report about a death we believe may be the result of criminal conduct.
- Report about a victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement.
- Report about any criminal conduct at our facility and in emergency circumstances to report a crime.
- Help identify or locate a suspect, fugitive, material witness or missing person.

Research

- To conduct a research project – to help find patients with specific health issues.
- To study the effectiveness of your treatment or medicine.
- All projects must go through a special process that protects the confidentiality of your medical information.
  - All projects must be approved by the FFHC Board of Directors.

Information may also be released in one of the following situations:

- Donor programs, if you are donating or in need of an organ, eyes or tissues.
- Medical examiners or coroners to help identify a body or find the cause of death.
- Funeral directors to help them carry out their duties.
- To prevent or lessen a serious threat to you or others.
- If you are in the military - as required by military rules.
- If you are an inmate:
  - To the correctional institution or law enforcement provide you with healthcare.
  - To protect your health and safety.
  - To protect the health and safety of others including the correctional institution.
- Report findings for an examination ordered by the court or to follow the laws for national safety reasons.
- We use and share information, as required by additional laws not mentioned above.

B. Situations information can be shared ONLY with your written permission. Any situation not mentioned above will require your permission. You must sign a form for the use or disclosure of any of your health information. Certain information is considered highly confidential and will require a signed form most of the time. Highly confidential information includes mental health notes, test or treatment of HIV/AIDS and other communicable diseases. You must give us written permission to release your information for marketing purposes.

C. Situations your information WILL NOT be shared. Any results of genetic testing for insurance underwriting purposes will not be disclosed. We will not sell your health information for any reason.

2. Your Rights Regarding Your Health Information

A. Receive or view your medical information. You may receive a copy or review your medical information. You must make an appointment to view your record for free. If you wish to receive a copy, you must sign a request form. Copies are available through the medical records department or the front office. You can receive an electronic copy or a paper copy depending on your preference. Charges may apply for these requests. In some cases, we may lot let you see or copy your record. If this happens, we will tell you why and explain your right to have the denial reviewed.

B. Request changes to be made to your record. If you believe that your medical record is wrong or not complete you may request a change or amendment. You must put your request in writing and give a reason for why you want the change to be made. We will make the changes unless we believe that the information you want changed is complete and accurate. If we did not create the information, we cannot change it.

C. List of information shared with others. You have the right to request a list of disclosures we have made of your medical information. This does not include information released for treatment, payment or facility operation purposes. It will also not include any releases you have authorized yourself. This request must be in writing. The request will need to be for a specific time frame of up to six years. We will provide you 1 free accounting list per year.

D. Limit insurance from accessing records. You have the right to restrict certain information from being sent to your insurance company. You can restrict any visit, test, procedures, etc. if you paid for it yourself. As long as we are not required by law to disclose the information it will not be sent.

E. Restrict use or disclosure of your medical record. You have the right to request that FFHC not use or release your medical information for treatment, payment or healthcare tasks. We are not required to comply with this request. But will do our best to ensure your privacy. If we agree to the request, it will be followed unless there is an emergency reason we need to share your information.

F. Send information to you at a different address or contact you differently. You may request that we send information to a different address than the one we have listed as your home address. You do not need to give us a reason for this request. We do not have to comply with your request if it is unreasonable.

G. Withdraw signed authorization. You have the right to withdraw any authorization you have signed for the use or disclosure of your medical information. This request must be in writing. We will comply from the requested withdraw date forward. We are not responsible for any information that has been shared prior to your withdraw.

H. Receive paper copy of this Notice. You may request to receive a paper copy of this notice at your health center. If you wish to view this document electronically, it is posted on our website www.firstflighthealthcenters.org.

I. File a complaint. You have the right to file a compliant if you believe for any reason that your privacy has been violated. You may file a complaint by submitting a written complaint detailing how your privacy was violated. Complaints may be filed with FFHC complaint officer. You may also file with the Secretary of the Department of Health and Human Services on their website. Making a complaint will not change how you are treated at our health centers.

J. Notification of breach information. You have the right to be notified of any unsecure breach of your health information.

3. Applicability, Changes to this Notice, Contact Information, and Effective Date

This notice applies to all of your medical information maintained by FFHC, whether it is information we create or that we received from somewhere else. We reserve the right to change the terms of this Notice. Your privacy rights may change if the laws change. When that happens, we will change the Notice and post it where you will be able to read it. The new Notice will be used for all the information we have about you. We must follow the terms of the Notice that is currently in effect. If you wish to receive a copy of the most current Notice you may request it from your health center or view it electronically on our website. This Notice of Privacy Practices is effective September 23, 2013. If you have any questions concerning this Notice please contact our company compliance officer at (937) 586-9733 extension 1037.

First Flight Health Centers™

Billing Agreement

Health Insurance:

I am aware that it is my responsibility as the patient to give a copy of my insurance card to First Flight Health Centers at the time of my service. I authorize payment directly to FFHC and/or the physicians or their designees of the benefits for health services specified and otherwise payable to me but not to exceed the regular charges. I understand I am responsible for all charges until the bills are paid in full and for the balance of charges not covered by insurance. If for any reason my insurance company (including Medicare) denies payment, I authorize FFHC to act on my behalf to appeal for payment. *MEDICARE PATIENTS ONLY – I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder, including the physicians and/or their designees, of medical or other information about me to release to the Social Security Administration and/or the Medicare program any info. needed for this or related Medicare claim.

Self-Pay (Uninsured or Underinsured):

I am aware that it is my responsibility to complete a Sliding Fee Discount Application and return my proof of income within 30 days of my visit or I will be responsible for 100% of my bill.

Insurance Balances/Co-Pays/Sliding Fee Discount Nominal Fees:

I am aware that insurance balances/co-pays or Sliding Fee Discount nominal fees are my responsibility.
I may pay with cash, check, or credit card at the office, by calling the Billing Department, on the Patient Portal, or on the Instamed Portal (https://firstflighthealthcenters.org/pay-my-bill). *If a check payment is returned due to nonsufficient funds, the fees will be added to my account, and I will be responsible to pay.

Tele Visits and Wellness Vists:

I understand First Flight Health Centers provides Tele Visits with audio and/or video as an additional service to patients as need determines. I am aware these are billable services with an associated charge/cost similar to an in-office visit. I understand that when coming in for a scheduled Wellness/ Preventative Visit for insurance, if new health issues or illnesses are brought up to my Provider, my visit may no longer be billed as a Wellness/Preventative Visit and may be billed as a standard office visit. I am aware that any co-pays, co-insurances, deductibles, or sliding fee discount nominal fees applied for these visits will be my responsibility.

Statements:

I am aware that I will only receive 3 statements total before my account may be sent to an outside collection agency. I am also aware if FFHC receives returned mail because I have not supplied a correct/updated mailing address, I may be sent to an outside collection agency.

Payment Arrangements:

I am aware that if there is a balance due I may set the balance up on a Payment Plan if I am unable to pay in full. I am also aware that if I do not set up the payment plan with FFHC or I do not make my scheduled payments I may be sent to an outside collection agency. Payment Plans can be set up by contacting the Billing Dept. or on the Instamed Portal.

Collections:

I am aware that if I am sent to an outside collection agency two (2) times that I may be discharged from the practice and I will no longer be able to receive services at First Flight Health Centers.

My signature, or that of my authorized representative, indicates that I have read, understand and agree with the above conditions and I have provided accurate information.

_____ _____ _____
Patient/Guarantors Signature Relationship Date

_____ _____
Patient Name Printed Patient Date of Birth

First Flight Health Centers™

First Flight Health Centers is a federally qualified health center. We are required to collect the incomes of our patient population. All information is confidential and we are only required to report numbers not patient names. We will ask you to update this information yearly.

A family size is your immediate family who live in your home that you are legally responsible for and children you pay child support for that do not live in your home.

1. Circle your Family Size

2. Circle your <u>total household</u> income

<u>TOTAL HOUSEHOLD INCOME</u> (CIRCLE ONE AMOUNT ONLY)

Family Size	Income = Or Under	Income between	Income between	Income between	Income Over
1	$15,960	$15,961 - $21,227	$21,228 - $23,940	$23,941 - $31,920	$31,921
2	$21,640	$21,641 - $28,781	$28,782 - $32,460	$32,461 - $43,280	$43,281
3	$27,320	$27,321 - $36,336	$36,337 - $40,980	$40,981 - $54,640	$54,641
4	$33,000	$33,001 - $43,890	$43,891 - $49,500	$49,501 - $66,000	$66,001
5	$38,680	$38,681 - $51,444	$51,445 - $58,020	$58,021 - $77,360	$77,361
6	$44,360	$44,361 - $58,999	$59,000 - $66,540	$66,541 - $88,720	$88,721
7	$50,040	$50,041 - $66,553	$66,554 - $75,060	$75,061 - $100,080	$100,081
8	$55,720	$55,721 - $74,108	$74,109 - $83,580	$83,581 - $111,440	$111,441

Patient Name Printed:_____ Patient Date of Birth:_____

Patient/Guarantor Signature:_____ Today's Date:_____

FIRST FLIGHT HEALTH CENTERS
SLIDING FEE SCALE DISCOUNT APPLICATION

Patient Name_____ Date of Birth_____

Applicant Name (if not patient)_____ Relationship to patient_____

Street_____ City_____ State_____

Zip Code_____ Phone_____ Alt or Cell Phone_____

Please provide the following information for **all people in your immediate family who live in your home.** For purposes of assistance, **immediate family** is defined as the patient, the patient's spouse, and all of the patient's children under 18 (natural or adopted) who live in the patient's home, or that you are **legally responsible for**.

Name	Relationship to Patient	Annual/Monthly or Weekly *INCOME*	Gross Amount

Total # of persons in Family_____ Total # of children child support is paid on, but not living in home_____

Documentation of No Income: If you report $0 income, please explain below how you are surviving without income.

_____

_____

_____

By my signature *below* I attest that **I have an annual income of $0**

Patients Signature_____ FFHC Witness_____

***Acceptable forms of proof of income(most recent)*:** two check/paystubs, tax return or W-2, public assistance or Social Security letter, Child Support, alimony, unemployment, bank statements, Medical Assistance or Dept. of Social Services Certification Letter. (**Include ALL income**)

I understand that I must update this information if my situation changes and that a new Discount Application must be completed at least every twelve (12) months. I have received information explaining the program and I understand and agree to abide by the terms. I understand that if I am a self-pay patient; **I am responsible to pay at least $20 for each medical visit and/or $40 for each dental visit.** If an unpaid balance exists on my account after applying my Discount percentage, I agree to make payment arrangements and honor the terms. I understand that if I am unable to make a payment in any given month; I must contact the Billing Office prior to the due date to discuss my need to modify my payment arrangement.

Certification: I certify that the family size and income information shown above is correct**. I understand that documentation supporting my financial position is required before my discount can be approved and that I must provide this information within 30 days or prior to my next visit if sooner.**

_____ _____ _____

Patient Name (print) Signature of Patient or Guarantor Date of signature

Do **NOT** sign this page if you wish to be considered for a discount. Signing below will void the other side of this form.

WAIVER:

I choose not to complete the Sliding Scale Application at this time. I am waiving my right to any Discount to which I may other wise be entitled. I understand that I will be responsible for full payment of all charges at the time of service.

_____	_____	_____
Patient Name (print)	Signature of Patient or Guarantor	Date