Welcome to Women's Health Center of Isabella Citizens for Health, Inc. (ICH) and thank you for choosing us as your provider for women's health care. Our health care team is committed to providing you and your family or loved ones with the best health care possible. We are recognized by Blue Cross Blue Sheild as a Patient Centered Medical Home. As a Patient Centered Medical Home, our approach is to provide our patients with comprehensive health care, which is focused on all aspects of your health and overall well-being, including emotional, family, and social concerns.

What is a Patient Centered Medical Home?

- ***Patient-centered*** means that you and your health care are at the center of your medical home.
- ***Medical home*** begins with our practice, where a team of professionals, led by your personal provider, work together to ensure comprehensive and coordinated care.
- ***Patient Centered Medical Home*** is an approach to providing total health care where you join a team that includes health care professionals, trusted family members or loved ones (if you wish) and, most importantly, you.

As a patient of ICH, you will have access to:

- In office services including, but not limited to, wellness exams, adult immunizations, minor procedures, laboratory testing, nonstress tests, pre/post and perinatal care, and cancer screenings.
- Transportation Assistance
- Case Management to help with extended care needs, follow-up exams and education;
- An Enrollment Specialist to assist you with accessing care, affordable care, insurance assistance or enrollment
- Sliding Fee Discount Program for medical, behavioral health, pharmaceutical services eligible patients.
- ICH offers interpretation and translation services for foreign languages and limited English speakers.
  Servicios de interpretación y traducción para idiomas extranjeros y personas de habla inglesa limitada.
  - Translation services for Spanish-speaking patients - 1-989-756-0297.
  - *Servicios de traducción para pacientes de habla hispana - 1-989-756-0297.*

How You Can Help

- Ask your provider and team any questions you have.
- Keep in touch with your team, as questions arise about your health.
- Take care of your health by following the plan recommended by your team.
- Schedule a complete physical exam once a year.

- Complete our patient satisfaction survey to let us know how we're doing and how we can improve.

Additional Information:

- Afterhours: If it is a life-threating emergency, report to your nearest emergency room. ICH offers an afterhours answering service for questions or medical concerns. Patients may call the Center at **989-773-3411** and select the option to be connected to the 24/7 answering service. Only in an urgent situation will the answering service contact your Health Center Provider.
  Afterhours: Si se trata de una emergencia potencialmente mortal, informe a la sala de emergencias más cercana. ICH ofrece un servicio de respuesta fuera de horario para preguntas o inquietudes médicas. Los pacientes pueden llamar al Centro al 989-773-3411 y seleccionar la opción para conectarse al servicio de respuesta 24/7. Solo en una situación urgente el servicio de respuesta se comunicará con su proveedor del centro de salud.
- Advance Directive: We have Advance Directive forms that will designate a patient advocate and give directions for healthcare. This includes plans for emergency and end of the life care. If you would like a copy, please ask our office staff. This can be completed with family, friends, or your attorney. Once completed, please submit a copy to the Center to be included in your medical records. If you already have an Advanced Directive, please bring us a copy.
- Federal Tort Claims Act Deemed HRSA-Funded Health Center: Isabella Citizens for Health receives Health and Human Services funding and has federal Public Health Service deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals.

Patient forms, information about our services and hours of operation, biographical information about our providers, information about the Patient Portal and links to educational resources are posted on our website: www.isabellahealth.org

At ICH, we believe in a strong family/provider/patient relationship and want you to confide in us and seek our help. We hope you will ask us about any medical concern that you or your family members may have. We want to keep you healthy and make you feel at home in our office.

Sincerely,

The Staff of Isabella Citizens for Health Women's Health Center

Women's Health Center
of Isabella Citizens for Health, Inc.

Patient Name_____ Date_____

I have received the following documents and understand the policies outlined within. I have read the policies in their entirety and fully understand the information within relates to me. **(Please initial each line.)**

INITIAL: _____ General Consent for Treatment

INITIAL: _____ Patient and Center Rights and Responsibilities

INITIAL: _____ Missed Appointment & late arrival Policy

INITIAL: _____ I acknowledge I have received the **Notice of Privacy Practices** of Isabella Citizens for Health, Inc.

INITIAL:_____I acknowledge I have received the **Patient-Centered Medical Home** information from Isabella Citizens for Health, Inc**.**

Women's Health Center

Health History Form

Patient Name: _____ DOB: _____/_____/_____

Age: _____ Today's Date: _____ Preferred Pharmacy: _____

Do you have a regular (Family) Doctor? o **Yes** o **No If Yes, who? _____**
With Whom Do You Live? _____
Any Pets? o **Yes** o **No If Yes, Type? _____**

Medications (include supplements, inhalers, birth control and over the counter medications):

Name	**Strength**	**How often?**

Latex Allergy? o Yes o No

Allergies (especially medications, specify reaction):

_____
_____

Past Surgical History (please include year):

Appendectomy	Gall Bladder Removal	Tonsillectomy
Hernia Repair	Hysterectomy	Mastectomy
Ovaries	Pacemaker	Heart Stents
Tubal Ligation	Cystoscopy	D&C
LEEP	Salpingectomy	Endometrial Ablation
Anterior (Bladder) Repair	Posterior (Bowel) Repair	TOT
Hysteroscopy		

List of other surgical history:

_____
_____
_____
_____

Women's Health Center

Patient Name: _____ DOB: ____/____/____

Trauma, Hospitalizations, or Serious Illnesses:

***Have you seen other medical providers for routine or specialty care?** o Yes o No

1. Provider Name:	Date:	Seen for:
2. Provider Name:	Date:	Seen for:
3. Provider Name:	Date:	Seen for:
4. Provider Name:	Date:	Seen for:

*The care team will ask you to sign a release so we may obtain your records from these providers. Access to these records ensures we can give you the best care possible.

Health Hazards (quantity, frequency, and duration of use):
Alcohol: o Yes o No If yes, how often? _____
Tobacco: o Yes o No If yes, how often? _____What substance(s)? _____
*If you do not use tobacco now, have you in the past? o Yes o No | When did you quit? _____
Marijuana o Yes o No If yes, how often? _____
Caffeine: o Yes o No If yes, how often? _____
Drugs: o Yes o No If yes, how often? _____What substance(s)? _____
Vape: o Yes o No If yes, how often? _____

Occupational Concerns (Work Exposure): Your Occupation (Current or former):
_____ _____

Job Status: o Active o Retired

Menstrual History:
Age of First Menstrual Period: _____
Last Menstrual Period: _____
Interval of cycle (start one period to start of next) _____
Duration (# of days of bleeding) _____
Usual Flow: o Light o Moderate o Heavy
Pain: o None o Mild o Moderate o Severe
Spotting/Bleeding between periods? o No o Yes
Sanitary Protection? o Pads o Tampons o Both o Menstrual Cup
Any previous abnormal PAPS? o Yes oNo
Current Method of Birth Control _____ Problems? _____
Prior Method of Birth Control_____ Problems? _____

Women's Health Center

Patient Name: _____ DOB: _____/_____/_____

Sexual History:
Sexually active? o Yes o Not Currently o Never
Any problems with sex life? o Yes o No
# of Sex partners (in your lifetime) _____
Age at first intercourse? _____

Bladder History:
Any problem with leakage or bladder control? o Yes oNo

Screenings/ Tests: Have you had any of the following?
Colonoscopy: o Yes/Date: _____ o No
Recent Labs: o Yes/Date: _____ o No
Bone Density: o Yes/Date: _____ o No
Mammogram: o Yes/Date: _____ o No
Pap Smear: o Yes/Date: _____ o No

Pregnancies: (including miscarriages, abortions & tubal pregnancies)

Number	Year	Sex	Weight	Complications Fetal & Maternal	Vag./C-Section/ Miscarriage	Health (child)
1						
2						
3						
4						
5						
6						

Women's Health Center

Patient Name: _____ DOB:_____/_____/_____

<u>Medical History</u>: (Please circle which problem applies)

Personal Medical History			Family Medical History		
Yes	**No**	**Medical Problem**	**Yes**	**No**	**Relationship**
		Diabetes Mellitus			
		Hypertension (High Blood Pressure)			
		Hyperlipidemia (High Cholesterol)			
		Heart Disease (Heart Murmur, Heart Attack, Angina)			
		Blood Transfusions			
		Asthma			
		Blood clots in legs or lungs			
		Liver disease (Hepatitis, Jaundice)			
		Seizure, stroke, Migraines			
		Mental Illness (Depression, Anxiety)			
		Abdominal Problems (Peptic Ulcer, Reflux, Colitis, Pancreatitis, Gallbladder)			
		Kidney Stones, Urinary Tract Ailments			
		Anemia, Sickle Cell, Clotting disorder			
		Arthritis			
		Thyroid disease			
		Cancer – What type? _____			
		Gonorrhea/ Chlamydia/PID			
		HPV/Genital Warts/ Herpes/ Syphilis			
		Uterine Fibroids			
		Endometriosis			
		MRSA			
		Other:			

Isabella Citizens for Health, Inc.

Last Name:	First Name:	First Name Used:
Date of Birth:	Sex at Birth: □ Male □ Female	Social Security #:
Preferred Method of Contact: □ Text □ E-Mail □ Phone	Street Address:	
City:	State:	Zip Code:

Primary Phone:	Secondary Phone:	Secondary Address: (if applicable):
Email Address:		
Emergency Contact Name:	Relationship:	Phone:
Parent/Guardian Name (if under 18):		Parent/Guardian Phone:

As a Federally Qualified Health Center, we are required by the Federal Government to ask more questions than a typical demographic form. We ask about income because our low-income patients may qualify for discounted services. If you have any questions, please feel free to ask.

Primary Language
□ English
□ Spanish
□ Other:

Agricultural Worker
□ Yes
□ No

Are you a Veteran?
□ Yes
□ No

Race
□ Asian Indian
□ Chinese
□ Filipino
□ Japanese
□ Korean
□ Vietnamese
□ Other Asian
□ Native Hawaiian
□ Other Pacific Islander
□ Guamanian/Chamorro
□ Samoan
□ White
□ Black or African American
□ American Indian/Alaska Native
□ More than one race
□ Decline to answer

Ethnicity
□ Hispanic or Latino
□ Not Hispanic or Latino
□ Decline to answer

If you select Hispanic/Latino, refer to the information below:
□ Mexican, Mexican American, Chicano/a
□ Puerto Rican
□ Cuban
□ Another Hispanic, Latino/a, or Spanish Origin
□ Hispanic Latino/a, Spanish Origin, Combined

Sexual Orientation
□ Straight/heterosexual
□ Lesbian, gay, homosexual
□ Bisexual
□ Don't know
□ Decline to answer
□ Other:

Gender Identity
□ Male
□ Female
□ Trans: Female to Male
□ Trans: Male to Female
□ Genderqueer
□ Decline to answer
□ Other:

Student Status
□ N/A
□ Full Time
□ Part Time

Relationship Status
□ Single
□ Married
□ Divorced
□ Widowed
□ Partner
□ Legally Separated

Living/Housing Situation
Are you homeless?
□ Yes
□ No
Do you live in public housing?
□ Yes
□ No

Employment Status:
□ Full Time
□ Part Time
□ Not Employed

Employer:

Isabella Citizens for Health, Inc.

Guarantor Information

Guarantor (if not patient)	Relationship to patient:	Birth Date:
Adress:	Phone:	Employer:

Primary Insurance

Insurance Name:	Subscriber's Name:
Patient's Relationship to subscriber:	Date of Birth:
Policy #	Group #

Secondary Insurance

Insurance Name:	Subscriber's Name:
Patient's Relationship to subscriber:	Date of Birth:
Policy #	Group #

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Isabella Citizens for Health or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature **Date**

Isabella Citizens for Health, Inc.

Release to Family and Friends Involved in Health Care

Isabella Citizens for Health is committed to the protection of your personal medical information. We realize that in today's society your spouse, family members, or close friends may be involved with your care or the payment of your care. To protect your personal medical information, we need to know the individual(s) you wish to allow our staff to release or discuss your care or the payment of your care with. The center has my permission to release or discuss my personal medical information concerning the following:

CHECK ALL THAT CAN BE RELEASED:

☐ General Health Care ☐ Billing and Accounts ☐ Medications

☐ Insurance Information ☐ Appointments ☐ ALL Information

Isabella Citizens for Health may release or discuss my personal medical information, as indicated above, with any of the following individuals in person or by telephone.

1) _____ Relationship: _____Phone: _____

2) _____Relationship: _____Phone: _____

3) _____ Relationship: _____Phone: _____

4) _____ Relationship: _____Phone: _____

Release to Family and Friends Involved in Health Care (continued):

The information disclosed may include information relating to sexually transmitted infections, HIV/AIDS, or other communicable diseases. It may also include information about behavioral or mental health services, treatment, and/or testing for substance use disorders, and genetic testing. Any sensitive information listed above I wish to be **EXCLUDE** will be indicated here:

If you desire our staff to release or discuss any of the above listed items with your spouse, family members, or close friends, you must specifically authorize, in writing, for us to do so. Any Isabella Citizens for Health staff member will assist you. This document shall remain in effect until revised or revoked by you, the patient, or their authorized representative.

_____ _____

Print Name of Patient **Date**

_____ _____

Signature of Patient or Legal Representative **State Relationship to Patient**

_____ _____

Signature of Witness **Date**

Isabella Citizens for Health, Inc.

Patient Name: _____ Date of Birth: _____

Patient Demographics

Please complete the following information to help us better understand our patient population.

All information is kept confidential and is used for reporting purposes only.

If you have any questions, please ask our staff for help.

Family Size:

Family size or household size is described as total number of people under one roof. **Family Size: _____**

Household Income Data:

Definition of gross household income is the total amount of income (before taxes) for anyone in the household ages 19 and older from all sources including salaries, public assistance, unemployment, retirement payments, Social Security, child support, etc.

*****Please circle the correct gross income range for your household.**

$0-$3,644	$105,820-$108,261	$150,590-$162,799
$3,645-$20,349	$108,262-$109,889	$162,800-$183,149
$20,350-$40,699	$109,890-$112,331	$183,150-$203,499
$40,700-$61,049	$112,332-$122,099	$203,500-$223,849
$61,050-$81,399	$122,100-$142,449	$223,850-$244,199
$81,400-$101,749	$142,450-$146,519	$244,200-$264,550
$101,750-$105,819	$146,520-$150,589	Over $264,551

Isabella Citizens for Health, Inc.

General Consent for Treatment

I hereby and voluntarily consent to authorizing the Center's health care providers to provide health care services to me at the Center's service locations. The health care services may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical and/or dental treatment; routine laboratory procedures and tests; x-rays and other imaging studies; administration of medication; and procedures and treatments prescribed by the Center's health care providers. The health care services also may include counseling necessary to receive appropriate services including family planning (as defined by federal laws and regulations).

I understand that I will be asked to sign a separate informed consent for each vaccine to be administered to me and that I will receive a "Vaccine Information Statement" (VIS) prior to receiving each vaccine. I understand that there is a separate consent form that I may be asked to sign to be tested for infectious conditions.

I understand that there is a separate consent for telehealth visits.

I understand that there are certain hazards and risks connected with all forms of treatment, and my consent is given knowing this.

I understand that this consent is valid and remains in effect as long as I am a patient of the Center, until I withdraw my consent, or until the Center changes its services and asks me to complete a new consent form.

I understand that my treatment, payment, enrollment, and eligibility for benefits aren't conditioned by my signature on this form.

<u>Consent Provisions</u>

My signature on this acknowledgement form indicates that:

1. I certify that I have read and fully understand the foregoing consent and that the facts indicated above are true.
2. I realize that although every effort will be made to keep all risks and side effects to a minimum, risks, side effects, and complications can be unpredictable both in nature and severity.
3. I understand that midlevel providers (Physician Assistants and Advanced Practice Registered Nurses) may be involved in my treatment I consent thereto.
4. I understand that I may be asked to sign a separate informed consent for certain treatment(s) that require such.
5. I hereby voluntarily give my consent to treatment at the Center.

_____ _____

Patient Signature Date

Revised Jan 17, 2024

Isabella Citizens for Health, Inc.

Patient Name: _____
DOB: _____
Cell Phone: _____
Email Address: _____

Patient Email and Text Message Informed Consent

Isabella Citizens for Health, Inc. (ICH) and its affiliates, agents, independent contractors and any "covered entity" or "business associate" (as those terms are defined by the HIPAA Privacy Rule) with which your information may be shared under HIPAA (collectively, "Isabella Citizens for Health, Inc.") may communicate with you by email, text message, and/or other forms of unencrypted electronic communication (together, "Electronic Messaging") to the telephone number(s), email address(es), or other locations reflected in your medical record or as otherwise provided below. This form provider information about ICH's use, risks, and conditions of Electronic Messaging. It will also be used to document your consent for ICH's communication with you by Electronic Messaging.

How we will use Electronic Messaging: ICH may use Electronic Messaging to communicate with you regarding a wide range of healthcare related issues, including, but not limited to:

- Reminders of appointments or actions for you to take before an appointment, follow-ups from appointments, including copies of lab and radiology results, and notices about preventive services, treatment options, coordination for your care, and other available health services.
- How to participate in patient satisfaction surveys or how to use our secure patient portal; and
- Information regarding insurance, billing, eligibility for programs/benefits, and account balances.

ICH may use automatic dialers, broadcast messaging, or pre-recorded voice message when it communicates with you through Electronic Messaging. All Electronic Messaging may be made part of your medical record.

Risk of using Electronic Messaging: Electronic Messaging has a number of risks that you should consider, including:

- Electronic Messaging can be circulated, forwarded, sent to unintended recipients, and stored electronically and/or on paper.
- Senders can easily misaddress Electronic Messaging and send information to an unintended recipient.
- Backup copies of Electronic Messaging may exist even after deletion.
- Electronic Messaging may not be secure and can possibly be intercepted, altered, forwarded, or used without authorization or detection.
- Electronic Messaging service providers may charge for calls or messages received.
- Employers and online providers have a right to inspect Electronic Messaging sent through their company systems.
- Electronic Messaging can be used as evidence in court.

Conditions for the use of Electronic Messaging: ICH cannot guarantee, but will use reasonable means to maintain, the security and confidentiality of the messages we sent. By signing where indicated below, you acknowledge your consent to the use of Electronic Messaging on the following conditions:

- **IN A MEDICAL EMERGENCY, DO NOT USE ELECTRONIC MESSAGING. CALL 911.**
- Electronic Messaging may be filed in your medical record.

- ICH is not liable for breaches of confidentiality caused by you or any third party.
- You are solely responsible for any charges incurred under your agreement with your Electronic Messaging service provider (for example, on a per minute, per message, per unit-of-data-received basis or otherwise).

Expiration and Withdrawal of Consent: Unless you withdraw your consent earlier, this consent will expire upon the end of your treatment relationship with ICH. You may choose to stop participating in Electronic Messaging at any time by informing ICH in writing. You further understand that withdrawing this consent will not cause you to lose any benefits or right to which you are otherwise entitled, including continued treatment, payment or enrollment or eligibility for benefits. To withdraw your consent and stop participating in Electronic Messaging, please contact the ICH Privacy Officer as described in the Notice of Privacy Practices.

Patient Acknowledgement and Agreement: I have read and fully understand this consent form. I understand the risks associated with the use of Electronic Messaging between ICH and me, and I consent to the conditions and instructions outlined, as well as any other instructions that ICH may impose to communicate with me by Electronic Messaging. By signing below, I consent to receiving text messages and emails from ICH. I understand that ICH will send Electronic Messaging to those telephone number(s) and email address(es) in listed in my medical record.

Release: In consideration of ICH's services and my request to receive Electronic Messaging as described herein, I hereby release ICH from any and all claims, causes of action, lawsuits, injuries, damages, losses, liabilities or other harms resulting from or relating to the calls or messages, including but not limited to any claims, causes of action, or lawsuits based on any asserted violations of the law (including without limitation the Telephone Consumer Protection Act, the Truth in Caller ID Act, the CAN-SPAM Act, the Fair Debt Collection Practices Act, the Fair Credit Reporting Act, the Health Insurance Portability and Accountability Act, any similar state and local acts or statutes, and any federal or state tort or consumer protection laws.

Patient (or Authorized Representative) Signature	Patient's Printed Name	Date

Patient Name:_____ DOB:_____ Date:_____

COMPLETING THIS QUESTIONNAIRE IS <u>OPTIONAL</u>

The health center is pleased to assist you with resources and services that may help improve difficult situations and reduce or eliminate barriers to better physical and mental health. If you indicate that you have a hardship or a basic need through your answers below, our Community Health Worker (CHW) will contact you by calling the phone number you've provided upon establishing as a patient at the health center. A CHW is knowledgeable about area services and resources that offer assistance and access to basic needs such as food, clothing, utilities, housing, transportation, access to medical care, substance use services, and more.

1. What is your housing situation today?
    a. I have housing
    b. I do not have housing (staying with others, in a shelter, in a hotel, outside, in a car or in a park)
    c. I choose not to answer
2. Are you worried about losing your housing?
    a. Yes
    b. No
    c. I choose not to answer
3. What is your current work situation?
    a. Full time work
    b. Part time or temporary work
    c. Unemployed and seeking work
    d. Otherwise unemployed but not seeking work (ex. Student, disabled, unpaid primary caregiver)
    e. Retired
    f. I choose not to answer
4. Are you or any family members living with you currently in need of any of the following?
    a. Food
    b. Utilities
    c. Medicine
    d. Clothing
    e. Childcare
    f. I choose not to answer
5. Has the lack of transportation kept you from getting to medical appointments, meetings, work, or getting things for your daily needs?
    a. Yes
    b. No
    c. I choose not to answer
6. How often do you see or talk to people that you care about and feel close to?
    a. Less than once a week
    b. 1-2 times/ week
    c. 3-5 times/ week
    d. More than 5 times/ week
    e. I choose not to answer
7. Who are the people or groups you usually see or talk to at these times?
    a. Please list: _____
    b. I choose not to answer

Isabella Citizens for Health, Inc.

New Patient Appointment Checklist

Please plan to arrive 30 minutes before your scheduled appointment time. This will allow our reception staff to verify information, collect co-pays, and update your medical record demographics information.

_____ Complete your new patient paperwork and bring it with you to your appointment. Be sure to include the names, addresses and phone numbers of other health care providers you have visited. Our team functions most effectively as a medical home when you provide a complete medical history and information about care obtained outside the practice.

Paperwork to complete and bring with you:

- Document Acknowledgement Form
- General Consent for Treatment
- Email and Text Consent
- Health History Form
- Patient Demographics and Information Release Form

_____ Make a list of your health questions. Ask a friend or relative for help if you need it. Put the questions that are most important at the top of your list. Your provider may not be able to address everything in one visit but will prioritize based on your current health and medical conditions.

_____ Bring all of your medications in their original containers to your appointment. Be sure to include prescription, over the counter, natural and herbal medicines, and vitamins.

_____ Bring your current insurance card(s) and photo ID.

_____ If you wish, ask a family member or trusted friend to come with you to your appointment.

_____ Review the Sliding Fee Discount Program card included in your New Patient Folder to see if you may be eligible for this program.

Isabella Citizens for Health, Inc.

NOTICE OF PRIVACY PRACTICES

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

If you have any questions about this Notice, please contact the Center's Privacy Officer at (989) 953-5191 x4.

WHO WILL FOLLOW THE PRIVACY PRACTICES DESCRIBED IN THIS NOTICE

This Notice of Privacy Practices (Notice) describes the privacy practices of Isabella Citizens for Health, Inc. (the Center) and its workforce members (including employees, contractors, physicians, nurses, other licensed or certified personnel, volunteers, and front desk, billing and administrative personnel) who have a need to use your health information to perform their jobs. It also applies to any individuals authorized to enter information into your Center record. Your other health care providers may have different policies regarding their use and disclosure of your health information created at their location.

ABOUT YOUR HEALTH INFORMATION

We understand that health information about you and your health is personal and protecting your health information is important to us. We create a record of the care and services at the Center. We need this record to provide you with quality care and to comply with certain legal requirements.
This Notice applies to all of the records of your care generated by the Center, whether made by Center personnel or other health care providers, whether stored and transmitted electronically or by other means. We are required by law to:

- Maintain the privacy of health information that identifies you (with certain exceptions);
- Give you the Notice of our legal duties and privacy practices with respect to health information we collect and maintain about you; and
- Follow the terms of this Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH IN FORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose health information. Following each category is an explanation. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **DISCLOSURE AT YOUR REQUEST.** We may disclose health information when requested by you. This disclosure at your request may require a written authorization by you.

- **FOR TREATMENT.** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurse, technicians, students, and other Center personnel who are involved in taking care of you at the Center. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Additionally, the doctor may need to tell the case manager if you have diabetes so we can arrange for

appropriate follow up. Different areas of the Center also may share health information about you in order to coordinate the different care you need, such as medications, lab work, and x-rays. We also may disclose health information about you to people outside the Center who may be involved in your healthcare after you leave the Center, such as nurses, social workers, or family members. We may also use and disclose health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

The Center records and transmits health information, including prescription information, electronically. Health information is shared and protected electronically through local, state, and national health information exchanges. These networks have rules regarding how health information can be accessed, and limits on use or disclosure of that information.

- **FOR PAYMENT.** We may use and disclose health information about you so that the treatment and services you receive at the Center may be billed to and payment may be collected from you, an insurance company or a third party such as Workers' Compensation. For example, we may need to give your health plan information about a procedure you received at the Center so your health plan will pay us or reimburse you for the procedure or encounter. We may also tell your health plan about treatment you are going to receive to obtain prior approval or to determine whether your health plan will cover the treatment.

- **FOR HEALTH CARE OPERATIONS.** We may use and disclose health information about you for our health care operations activities. These uses and disclosures are necessary to operate the Center efficiently and make sure that all of our patients receive quality care. For example, we may use health information to review the safety and quality of our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine and analyze health information about many Center patients to decide what additional services the Center should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, students, volunteers and other Center personnel for review and learning purposes. Additionally, we may combine the health information we have with health information from other Centers to compare how we are doing and to see where we can make improvements in the care and services we offer. We may remove information that identified you from this set of health information so others may use it to study health care and health care delivery without learning who the specific patients are.

ADDITIONAL USES AND DISCLOSURES OF HEALTH INFORMATION

- **AS REQUIRED BY LAW.** We will disclose health information about you when required to do so by federal, state, or local laws or regulations.

- **DIRECTORY.** We may include certain limited information about you in the Center directory while you are a patient at the Center. This information may include your name, location at our facility, general condition, and religious affiliation to clergy. Unless there is a specific written request to the Privacy Officer listed herein to the contrary, this directory

information may be released to people who ask for you by name.

- **SIGN-IN SHEET.** We may use and disclose health information about you by having you sign in when you arrive at the Center. We may also call out your name when you are ready to be seen.

- **APPOINTMENT AND PATIENT RECALL REMINDERS.** We may use and disclose your health information to contact you to remind you regarding appointments or for health care that you are to receive.

- **BUSINESS ASSOCIATES.** Some of our functions are accomplished through contracted services provided by Business Associates. A Business Associate may include any individual or entity that receives your health information from us while performing services for the Center. Such services may include, without limitation, legal, actuarial, accounting, consulting, data aggression, management, administrative, accreditation or financial services. When these services are contracted, we may disclose your health information to our Business Associates so that they can perform the jobs we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

- **DISASTER RELIEF.** We may disclose information about you to an entity assisting in disaster relief so that your family can be notified about your condition, status, and location.

- **FUNDRAISING.** We may use information about you in an effort to raise money for the Center and its operations. We may disclose health information to a foundation related to the Center so that the foundation may contact you in raising money for the Center. We would only release contact information, such as your name, address and phone number and the dates you received treatment or services at the Center. If you do not want the Center to contact you for fundraising efforts, you must notify the Center's Chief Executive Officer at: (989) 953-5191 and in writing at: Jennifer White, 2790 Health Parkway, Mt. Pleasant, MI 48858. Additionally, each fundraising communication will include an opt-out opportunity.

- **HEALTH-RELATED PRODUCTS AND SERVICES.** We may use and disclose health information to tell you about our health-related products or services that may be of interest to you.

- **FAMILY, FRIENDS. OR OTHER INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE.** We may disclose your health information to notify or assist in notifying a family member, your personal representative, or another individual involved in or responsible for your health care about your location at the Center, your general condition, or in the event of your death. We may also disclose information to someone who helps arrange for payment for your care. If you are able and available to agree or object, we will give you the opportunity to agree or object prior to making these disclosures, although we may disclose this information in the case of a disaster even over your objection if we believe it is necessary to respond to the disaster or emergency situation. If you are unable or unavailable to agree or object, we will use our best judgment in any communication with your family, personal representative, or other involved individuals.

- **RESEARCH.** Under certain circumstances, we may use and disclose health information

about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with patients' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process. However, we may also disclose health information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the health information they review does not leave the Center.

- **TO PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. For example, we may notify emergency response personnel about a possible exposure to Acquired Immune Deficiency Syndrome (AIDS) and/or Human Immunodeficiency Virus (HIV). Any such disclosure, however, would only be to the extent required or permitted by federal, state, or local laws and regulations.

- **CHANGE OF OWNERSHIP.** If the Center is sold or merged with another organization, your health information/medical record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another Center, medical group, physician, or other healthcare provider.

SPECIAL SITUATIONS

- **FUNERAL DIRECTORS, CORONORS AND MEDICAL EXAMINERS.** We may disclose your health information to funeral directors as necessary to carry out their duties. We may also disclose health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death.

- **HEALTH OVERSIGHT ACTIVITIES.** We may disclose your health information to a health oversight committee for activities authorized by federal, state, or local laws and regulations. These oversight activities include, for example, audits, inspections, licensure reviews, investigations into illegal conduct, compliance with other laws and regulations. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **INMATES.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the institution or law enforcement official, if the disclosure is necessary (a) for the institution to provide you with health care; (b) to protect your health and safety to the health and safety of others; or (c) for the safety and security of the correctional institution.

- **LAW ENFORCEMENT.** We may release information if asked to do so by a law enforcement official in the following circumstances: (a) in response to a court order, subpoena, warrant, summons, or similar process; (b) to identify or locate a suspect fugitive, material witness, or missing person; (c) about the victim of a crime, if, under certain limited circumstances,

we are unable to obtain the person's agreement; (d) about a death we believe may be the result of criminal conduct; (e) about criminal conduct at the Center; (f) in emergency situations to report a crime; the location of a crime or victims; or the identity, description or location of the person who committed the crim.

- **LAWSUTTS AND DISPUTES.** If you are involved in a lawsuit or dispute, we may disclose your health information to the extent expressly authorized by a court of administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if reasonable efforts have been made to notify you of the request (which may include written notice to you) and you have not objected, or to obtain on order protecting the information requested.

- **MILITARY AND VETERANS.** If you are a member of the armed forces, we may release health information about you as required by military authorities. We may also release health information about foreign military personnel to appropriate foreign military authority.

- **NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES.** We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **ORGAN AND TISSURE PROCUREMENT ORGANIZATIONS.** If you are an organ donor, we may disclose health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary, to facilitate organ or tissue donation and transplantation.

- **PROTECTIVE SERVICES FOR THE PRESIDENT AND OTHERS.** We may disclose health information about you to authorize federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or to conduct special investigations.

- **PUBLIC HEALTH REPORTING.** We may disclose health information about you for public health activities. We will only make this disclosure if you agree or when required or authorized by law. These activities generally include the following: (a) to prevent or control disease, injury, or disability; (b) to report births and deaths; (c) to report the abuse or neglect of children, elders, or dependent adults; (d) to report reactions to medications or problems with products; (e) to notify people of recalls of products they may be using; and (f) 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.

- **VICTIMS OF ABUSE, NEGLECT OR DOMESTIC VIOLENCE.** We may disclose your health information to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure when required or authorized by law.

- **WORKERS' COMPENSATION.** We may disclose health information about you for workers' compensation or similar programs. These programs provide benefits for work-related

injuries or illness.

- **SECURITY CLEARANCES.** We may use medical information about you to make decisions regarding your medical suitability for a security clearance or service abroad. We may also release your medical suitability determination to the officials of the Department of State who need access to that information for these purposes.

- **MULTIDISCIPLINARY PERSONNEL TEAMS.** We may disclose health information to a state or local government agency or a multidisciplinary personnel team relevant to the prevention, identification, management or treatment of an abused child and the child's parents, or elder abuse and neglect.

- **SPECIAL CATEGORIES OF HEALTH INFORMATION.** In some circumstances, your health information may be subject to additional restrictions that may limit or preclude some uses or disclosures described in his Notice of Privacy Practices. For example, there are special restrictions on the use and/or disclosure of certain categories of health information such as: (a) AIDS treatment information and HIV test results; (b) treatment for mental health conditions and psychotherapy notes; (c) alcohol, drug abuse and chemical dependency treatment information; and/or (d) genetic information; are all subject to special restrictions. In addition, government health benefit programs, such as Medicare or Medicaid, may also limit the disclosure of patient information for purposes unrelated to the program.

YOUR PRIVACY RIGHTS

You have the following rights regarding health information we maintain about you:

- **RIGHT TO INSPECT AND COPY.** You have the right to inspect and copy health information that may be used to make decisions about your care. Usually this includes medical and billing records but may not include some mental health information. If you request a copy of your health information that may be used to make decisions about your care, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to:

  Isabella Citizens for Health, Inc.
  2790 Health Parkway
  Mt. Pleasant, MI 48858
  Attn: Medical Records

  We may deny your request to inspect and copy in specific circumstances. If you are denied access to your health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Center will review your request and the denial. The person conducting the review will not be the person who denied your request. The Center will comply with the outcome of the review.

- **RIGHT TO REQUEST RESTRICTIONS.** You have the right to request a restriction or limitation on the health information the Center uses or discloses about you for treatment, payment or health care operations. You can also request a restriction or limitation on the health information we disclose about you to someone who is involved in your care or the

payment for your care, like a family member or friend. For example, you could ask that we do not use or disclose information about a surgery you had.

- **RIGHT TO RESTRICT DISCLOSURE FOR SERVICES PAID BY YOU IN FULL.** You have the right to restrict the disclosure of your health information if the health information pertains to health care services for which you paid in full directly to the Center and the disclosure is not otherwise required by law.

- **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 to your health information for as long as the information is kept by or for the Center. You must make your request to amend your health information, in writing, and submit it to the Center at the above address. You must include a reason that supports your request. In addition, we may deny your request if you ask us to amend information that:

  1. Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  2. Is not part of the health information kept by or for the Center;
  3. Is not part of the information in which you would be permitted to inspect and copy; or
  4. Is accurate and complete.

  The law permits us to deny your request for an amendment if it not in writing or does not include a person to support the request.

  Even if the Center denies your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your medical record, we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

- **REQUEST AN ACCOUNTING OF DISCLOSURES.** You have the right to request an "accounting of disclosures." Such an accounting is a list of the disclosures we made of health information about you other than our own uses for treatment, payment, and health care operations (as those functions are described above) and with other expectations pursuant to law. To request this list or accounting of disclosures, you must submit your request in writing to the center at the above address. Your request must state a time period that may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list 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.

- **RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. You must make your request for confidential communications in writing to the Center at the address noted above. We will not ask you the reason for your request. We will accommodate all

reasonable requests. Your request must specify how or where you wish to be contacted.

- **RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE.** You have the right to receive a paper copy of this Notice. You may request a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.
- **RIGHT TO NOTICE OF BREACH.** You have the right to be notified if we or one of our Business Associates becomes aware of an improper disclosure of your health information.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time. We reserve the right to make the revised or changed Notice effective for all health information we have about you as well as any information we receive in the future. We will post a copy of the current Notice in the Center. The Notice will contain the effective date. If we amend this Notice, we will offer you a copy of the current Notice in effect. You may request a copy of the current Notice each time that you visit the Center for services or by calling the Center and requesting that the current Notice be sent to you in the mail.

FOR MORE INFORMATION, TO FILE A COMPLAINT OR TO REPORT A PROBLEM

If you believe that your privacy rights have been violated, please let us know promptly so we can address the situation. You may file a complaint with the Center and/or with the Secretary of the Federal Department of Health and Human Services. All complaints must be submitted in writing.

To file a complaint with the Center, send a written complaint to the Center's Privacy Officer at:

Isabella Citizens for Health, Inc.
2790 Health Parkway
Mt. Pleasant, MI 48858
Attn: Director of Operations

If you would like to discuss a problem without submitting a formal complaint, you may contact the Director of Operations by telephone (989) 953-5191 x4; or by facsimile at (989) 772-7656. ***You will not be penalized for filing a complaint.***

OTHER USES FOR 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 stop the uses and disclosures allowed by that permission, expect to the extent that we have already acted in reliance on your permission. For example, we are unable to take back any disclosures we have already made with your permission.

ACKNOWLEDGEMENT OF RECEIPT OF NOTJCE

We will ask you to sign on acknowledgement that you received this Notice. Effective date: March 15, 2022.

Isabella Citizens for Health, Inc.

Patient and Center Rights and Responsibilities

Welcome to the Center. Our goal is to provide quality access to health care to our community, regardless of ability to pay. As a patient, you have rights and responsibilities. The Center also has rights and responsibilities. We want you to understand these rights and responsibilities so you can help us provide better care to you. Please read this document, ask us any questions you have, then sign the acknowledgement statement.

A. Human Rights

You have the right to be treated with respect regardless of race, color, socio-economic status, marital status, religion, gender, gender identity, sex, sexual orientation, housing status, national origin, ancestry, physical or mental handicap or disability, age, family status, veteran status, or other grounds as applicable by federal, state, and local laws or regulations.

B. Payment for Services

1. You are responsible for giving our staff accurate information about your present financial status and any changes in your financial status. The staff need this information to decide how much to charge you and/or so they can bill private insurance, Medicaid, Medicare, or other benefits for which you may be eligible.

    a. The Center has created a Sliding Fee Discount Program, which allows patients who meet the necessary criteria to receive their care at a discounted rate. The discount is based on household size and income. To determine your eligibility for the Sliding Fee Discount Program, you will be asked to fill out an application. The application will ask some personal questions about the financial situation of your household. You will be asked to provide proof of your entire household income. This includes, but is not limited to, wages, government assistance, child support/alimony, social security benefits, and any other financial assistance. A member of the Center staff is available to assist you if you needed.

2. You have a right to receive an explanation of the Center's bill(s). You must pay, or arrange to pay, all agreed fees for services. If you cannot pay right away, please let staff know so they can continue to provide care to you and develop your payment plan.

    Self-pay patients may pay $75 per face-to-face primary care medical encounter or a behavioral health encounter with a provider when the payment is made at the time of service.
    Self-pay patients may pay $125 per face-to-face medical encounter with a Center Psychiatrist when the payment is made at the time of service.

3. Federal law prohibits the Center from denying you primary care services which are medically necessary solely because you cannot afford to pay or unable to pay for services. However, this is not true when a patient is unwilling to pay.

C. Privacy

You have a right to have your conversations, examinations, and treatment in privacy. Your medical records are also private. Only legally authorized persons may view your medical records unless you request in writing for us to show them to, or copy them for, someone else. In certain instances, the Center may be required to report to the Michigan Department of Community Health regarding your health condition or disease status. A complete explanation of your privacy rights will be given to you, labeled as the Center's Notice of Privacy Practices, along with this document. Staff will request that you acknowledge your receipt of our Notice of Privacy Practices. The Notice of Privacy Practices sets forth the ways in which your medical records may be used or disclosed by the Center and the rights granted to you under the Health Insurance Portability and Accountability Act ("HIPAA").

D. Health Care

1. You are responsible for providing the Center complete and current information about your health or illness, so that we can provide proper health care. You have a right, and are encouraged, to participate in decisions about your care plan and treatment.
2. You have a right to information and explanation in a language that you understand. Translation services are available, if needed. You have a right to information about your health or illness, treatment plan, including the nature of your treatment; its expected benefits; its inherent risks and hazards (and the consequences of refusing treatment); the reasonable alternatives, if any (and their risks and benefits); and the expected outcome, if known. This information is called obtaining your informed consent.
3. You have the right to receive information regarding "Advance Directives." If you do not wish to receive this information, or if it is not medically advisable to share that information with you, we will provide it to your legally authorized representative.
4. You are responsible for appropriate use of Center services, which includes following staff instructions and making and keeping scheduled appointments. Center professionals may not be able to see you unless you have an appointment.
5. If you are an adult, you have the right to refuse treatment or procedures to the extent permitted by applicable laws and regulations. In this regard, you have the right to be informed of the risks, hazards, and consequences of refusing such treatments or procedures. Your receipt of this information is necessary so that your refusal will be "informed." You are responsible for the consequences and outcome of refusing recommended treatment or procedures. If you refuse treatment or procedures that your

health care providers believe is in your best interest, you may be asked to sign a refusal to consent form.

6. You have the right to health care and treatment that is reasonable for your condition and within our capability, however, the Center is not an emergency care facility. You have a right to be transferred or referred to another facility for services that the Center cannot provide. The Center does not pay for services that you receive from another health care provider.
7. If you are in pain, you have a right to receive an appropriate assessment and pain management, as appropriate.

E. Center Rules

1. You have a right to receive information on how to appropriately use the Center's services. You are responsible for using the Center's services in an appropriate manner. If you have any questions, please ask.
2. You are responsible for the supervision of children you bring into the Center. You are responsible for the children's safety and the protection of other patients and our property.
3. You have a responsibility to attend your scheduled appointments and be on time. Missed appointments cause delay in treating other patients. If you do not attend your appointments and be on time, you may be subject to disciplinary action pursuant to the Center's policies and procedures.

F. Formal Complaints

1. If you are not satisfied with our services, please tell us. We want suggestions so we can improve our services. Staff will guide you on how to file a formal complaint. If you are not satisfied with how management responds to your complaint, you may request that your complaint is presented to the Center's Board of Directors.
2. If you make a formal complaint, no Center representative will punish, discriminate, or retaliate against you for filing a complaint, and the Center will continue to provide you services.

G. Termination of Patient/Center Relationship

If the Center decides that we must stop treating you as a patient, you have a right to advance written notice that explains the reason for the decision, and you will be given thirty (30) days to use our health center. However, the Center can decide to stop treating you immediately, and without written notice, if you create a threat to the safety of the staff and/or other patients. You have a right to receive a copy of the Center's Termination of the Patient and Center Relationship Policy.

Reasons for which we may stop treating you include:

1. Failure to obey Center rules and policies, such as keeping scheduled appointments;

2. Intentional failure to accurately report your financial status; unwillingness to pay for services
3. Intentional failure to report accurate information concerning your health or illness;
4. Intentional failure to follow a treatment plan, such as instructions about taking medications, personal health practices, or attending follow up appointments, as recommended by your health care provider(s), and/or
5. Creating a threat to the safety of the staff and/or other patients.

H. <u>Appeals</u>

If the Center has given you a notice of termination of the patient and Center relationship, you have the right to appeal the decision to the Center's Compliance and Process Improvement (CPI) Committee.

Isabella Citizens for Health, Inc.

Missed Appointment & Late Arrival Policy

It is the responsibility of the Center to provide convenient scheduling as well as maintain availability for all patients. The opportunity for the health center to provide this availability greatly diminishes when there are missed appointments or "no shows", which is when the patient does not call the health center to cancel or reschedule at least 24 hours in advance.

Additionally, it is the responsibility of the health center to make every reasonable effort not to turn patients away. The Center recognizes that its patient population may have difficulty securing reliable transportation, and thus may arrive late to an appointment due to circumstances beyond the patient's control.

If three or more appointments are missed in any six-month period, the patient risks or potentially forfeits the privilege of receiving an advanced scheduled appointment and will only be allowed a "same day" appointment.

Late patients have the option of rescheduling their appointment or waiting for their provider to fit them into the schedule same day. The Center cannot say with certainty how long a late patient's wait will be, or if the patient will be seen at all as a same-day appointment. Receptionists will assess these situations with the providers on a case-by-case basis.

Referral's

Referral's will be placed to the recommended specialists, that your provider feels will fulfill your care.

Keep in mind due to the specialist's availability and the insurance the specialist participate you may have to travel.

Revised 3/24/22

Isabella Citizens for Health, Inc.

Patient Centered Medical Home Patient-Provider Agreement

A Patient-Centered Medical Home is a trusting partnership between a provider-led healthcare team and an informed patient. It includes an agreement between the provider and the patient that acknowledges the role of each in the total health care program.

As your primary care provider, we will:

- Ask what your goal is, or what you want to do to improve your health.
- Ask you to help us plan your care and to let us know if you think you can follow the plan.
- Create written copies of care plans for more complex illnesses.
- Remind you when tests are due so that you can receive the best quality of care.
- Ask you to have blood tests before your visit so the provider has the results at your visit.
- Explore methods to care for you better, including ways to help you care for yourself.

We trust you, our patient, to:

- Tell us what you know about your health and illnesses.
- Tell us about your needs and concerns.
- Take part in planning your care.
- Follow the care plan that is agreed upon – or let us know why you cannot so we can try to help or change the plan.
- Tell us what medications you are taking and ask for refills at your office visits.
- Let us know when you see other doctors and what medications they put you on or change.
- Ask other doctors to send us a report about your care when you see them.
- Seek our advice before you see other physicians. We may be able to care for your needs.
- Learn about wellness and how to prevent disease.
- Learn about your insurance so you know what it covers.
- Respect us as individuals and partners in your care.
- Keep your appointments as schedule, or call and let us know when you cannot.
- Pay your share of the visit fee when you are seen in the office.
- Give us feedback so we can improve our services. *(We may ask you to complete a survey.)*

We look forward to working with you as your primary care provider in your patient centered medical home. You will receive a document to initial documenting that you have received this information.

Isabella Citizens for Health, Inc.

Outreach and Enrollment Services

Isabella Citizens for Health, Inc. has dedicated Health Insurance Navigators to assist individuals with accessing affordable care and insurance assistance or enrollment. You do not need to be a patient at Isabella Citizens for Health to get help from our Navigators.

Call Tara at (989) 953-5320 ext 7 or email tara.herald@isabellahealth.org or you can reach Derek at (989) 859-8716 or derek.gager@isabellahealth.org to schedule an in-person appointment.

Free assistance is available for:

- Health Insurance Enrollment
  - Marketplace
    - Available premium tax credits
    - Cost sharing reductions
    - Special Enrollment Periods
  - Medicaid Programs
- Sliding Fee Discount Program enrollment in the Center
- Completing various agency applications for patient assistance programs