Care Alliance Health Center (CAHC) is a non-profit federally qualified community health center providing comprehensive primary, and preventive medical, dental, behavioral health, lab, and transportation to families and individuals, regardless of the ability to pay. We are recognized as a Patient Centered Medical Home (PCMH) by the National Committee for Quality Assurance (NCQA), which is an innovative program for improving primary care for our patient population at the St. Clair location. Other sites of CAHC are striving for this recognition. The program gives practice information about organizing care around patient needs, working in teams, and coordinating and tracking care over time.

TO OUR VALUED PATIENTS:

CAHC strives to provide high quality, affordable health care to the residents in our service areas. Our medical providers are committed to keeping you and your family healthy, at rates you can afford.

CAHC is “not a free clinic”. To continue our current level of services, it will be necessary to collect fees from all of our patients when services are rendered. This includes the co-pays from Medicare, Medicaid and private insurance, as well as the minimum fee.

If you have insurance coverage, our staff will continue to file claims with your insurance company, Medicaid or Medicare on your behalf. If you think you might be eligible for Medicaid or the Health Insurance Marketplace, our staff will be available to help you with the process.

For patients who do not have insurance coverage, our fees will continue to be discounted, based on family income and size, if you provide the required documentation. For those who qualify, a minimum fee will be charged for each service performed. (Ex: Office visit, lab, etc.) Dental services have a higher minimum fee.

You may contact our Finance Department at (216) 535-9100 if you have any questions regarding fees and/or charges. The staff of Care Alliance Health Center is appreciative of your ongoing support of our facilities, and we look forward to serving you and your family for all of your healthcare needs.
Dear New Patient,

We would like to take this opportunity to welcome you to our practice and to thank you for choosing our physicians to participate in your healthcare. We look forward to providing you with personalized, comprehensive health care focusing on wellness and prevention. As continuity and coordination of patient care are essential in meeting your healthcare needs, our physicians, nurse practitioner, medical assistants, and office staff work closely in a “team approach” to support your patient care.

Our office is open Monday through Friday from 8:00am-4:30 pm. Evening appointments are available at our clinic locations (these hours may vary, please confirm with a Patient Service Representative). Every effort is made to see our patients for medical problems during daytime hours. Please note that our schedulers are available every day and will do their best to accommodate you. Booking an appointment is essential to ensuring all patients receive the time they require for quality medical care. After hours care will be provided by the on-call physician, who can be reached by calling our office directly.

As your primary care physician, we work collaboratively with various hospitals and specialists to coordinate all aspects of our patient care including inpatient hospitalization and specialty consultation care, as needed.

Before you visit, please notify your health insurance company of your new primary care provider if required. We also request that you contact your previous physician and specialists and request that a copy of your medical record be sent to us. If your former providers are affiliated with the Partners network, this should not be necessary.

Please fill out the enclosed forms and bring them with you to your appointment. During your initial visit, we will be reviewing your health status and these forms contain information necessary to complete this process. Please bring your health insurance identification card as well as a photo I.D. Please bring a complete list of all of your medications, as well as the strength and dose of each one.

Once again, we would like to thank you for choosing us as your primary health care provider. We look forward to working with you.

Sincerely,

The Providers and Staff of Care Alliance Health Center
Welcome to Your Patient-Centered Medical Home

Thank you for choosing us to be part of your health care team. We are committed to providing you the best health care possible by becoming a patient-centered medical home.

What is a patient-centered medical home?

A patient-centered medical home is a system of care in which a team of health professional's work together to provide all of your health care needs. Our goal is to provide care that is personalized for you.

Who is part of my medical home team?

Your primary care provider leads your care team. Other members include:

- Medical Providers
- Nurses
- Medical assistants
- Care coordinators
- Patient service representatives

The members of our team act as “coaches” who help you get healthy and stay healthy and provide the services that are right for you.

What Can You Expect?

In a patient–centered medical home, we:

- Help you understand your condition(s) and how to take care of yourself. We explain your options and help you make decisions about your care. We provide you with educational materials specific to your health.

- Know you and your health history. We know about your personal or family situation and can suggest treatment options that make sense for you.

- Provide appointments at times that are convenient for you

- Address behavioral health issues. Our practice can screen and treat you for behavioral health issues (such as depression) and connect you with other providers.

- Coordinate care to a trusted specialist, when needed, within Newton–Wellesley Hospital and the Partners Network. Your medical team and specialists work together and share the same electronic medical record system. This allows coordination of care so you can get better faster.

- Help transfer records from last provider. We can make your transition seamless. Contact us to get started.
MyChart Patient Portal (for non-urgent communication):

https://mychart.ochin.org/mychart/

• Our secure portal allows patients and care teams to interact, before, during and after office hours.
• Patients can schedule their own non-urgent appointments, medication refills and referrals.
• The portal allows patients to check lab and test results.

After Hours/Urgent Care:

A physician is available 24/7 for telephone consultation. Call our office and a physician will be paged for you.

We want you to be involved in your health care decisions. How can you help? Be an active team player:

• Ask health questions so you understand your diagnosis and needs.
• Communicate with your medical home team.
• Tell us about your other health care providers, including visits to the emergency department or urgent care

Take care of your health:

• Collaborate with the team to develop your health care plan.
• Set reachable goals.
• Make sure you understand how to follow the plan.
• Tell your team if you have trouble following the plan or taking your medications.
• Review the plan and change the goals as needed.

Have a checklist for your appointment.

• Bring a list of your questions with you.
• Ask the most important ones first.
• Write down the answers.
• Before you leave the office, be sure you know what you need to do until your next visit
No Show Policy

Care Alliance Health Center is committed to providing access and appointment availability to all of our patients in a manner that fits your needs and availability. In order to maintain this access, we currently strive to confirm appointments with everyone who has scheduled an appointment 24 hours in advance of that date and time.

If you will not be able to make your scheduled appointment, please contact the office as soon as possible to cancel or re-schedule your appointment. Missed appointments reduce access and increase costs for all of our patients by forcing other patients to seek costlier care options at urgent care centers and emergency departments.

Patients with 3 consecutive missed/no-show appointments may not schedule an appointment and must use walk-in availability only. At the time of the missed/no show reappointment Care Alliance Staff will assess and address any barriers that may be in place resulting in the missed/no show appointment.

Late Arrival Policy

Our providers do their best to keep appointments on schedule. Out of respect for patients who have arrived on time for their appointment, you may be asked to reschedule your appointment if you arrive later than your scheduled appointment time. We will make every effort to honor your appointment as a “work in” as the schedule allows upon arrival, but there may be times when this will not be possible and you will have to reschedule.

If you are running late, please contact the office as soon as become aware that you will not be on time. All patients are instructed to arrive 10 minutes prior to their scheduled appointment time to allow our staff the time to update your information. New patients are instructed to arrive 15 minutes prior to their scheduled appointment if they need to complete any portion of the new patient paperwork in the office. If all registration and health history paperwork is completed, then 10 minutes is sufficient for registration.
Welcome to Care Alliance Health Center! It is our privilege to serve you. Please read and complete this entire packet. We collect and update this information every year to make sure we are best serving your health care needs. Please feel free to ask a staff member for help if you have questions. Thank you!

**PATIENT REGISTRATION INFORMATION**

Last Name: ___________________________  First Name: ___________________________

Address: ________________________________

City: ___________________________  State: _______  ZIP: ____________

Birth Date: ___________________________  SS#: ___________________________

If patient is under the age of 18, please include parent/guardian’s name and info:

<table>
<thead>
<tr>
<th>Mother’s Name</th>
<th>Date of Birth</th>
<th>SS#</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father’s Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guardian’s Name</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CONTACT INFORMATION**

What is the best Telephone Number to call you at: ___________________________

Is this a cell phone: □ Yes  □ No

By providing us with a cell number, you agree to allow Care Alliance to contact you with reminder notices via voice or text messaging services.

□ Please check here if you prefer to opt out from receiving appointment reminders notices by voice or text message.

E-Mail address: ___________________________

Emergency Contact: (Who may we contact in case of an emergency?)

Name: ___________________________  Relationship to you: ___________________________  Phone: ___________________________
**Patient Information**

<table>
<thead>
<tr>
<th>Ethnicity: (check one)</th>
<th>Hispanic/Latino</th>
<th>Not Hispanic/Latino</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race: (check all that apply)</td>
<td>Black/African American</td>
<td>White/Caucasian</td>
</tr>
<tr>
<td></td>
<td>Alaskan Native</td>
<td>Asian</td>
</tr>
<tr>
<td></td>
<td>Other Pacific Islander</td>
<td>Native Hawaiian</td>
</tr>
</tbody>
</table>

| Primary Language: | English | Spanish | Other: ____________________________ |

<table>
<thead>
<tr>
<th>Gender:</th>
<th>Male</th>
<th>Female</th>
<th>Transgender male/man</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Transgender female/woman</td>
<td>Genderqueer, neither exclusively male or female</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other: ______________________</td>
<td>Decline to answer</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual Orientation:</th>
<th>Straight or Heterosexual</th>
<th>Lesbian, gay, or homosexual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bisexual</td>
<td>Something else: __________________________</td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>Decline to answer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Residence: (Where did you sleep last night? Where do you currently stay?)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Your own apartment or house</td>
<td>[ ] Cuyahoga Metropolitan Housing Authority (CMHA)</td>
</tr>
<tr>
<td>[ ] Homeless Shelter</td>
<td>[ ] Treatment Center</td>
</tr>
<tr>
<td>[ ] Doubling up (staying with friends or family)</td>
<td>[ ] Street, campsite</td>
</tr>
<tr>
<td>[ ] Permanent Supportive Housing</td>
<td>[ ] Temporary Supportive Housing</td>
</tr>
</tbody>
</table>

| Are you a veteran of the U.S. Armed Forces? | [ ] Yes | [ ] No |

| Employment: Are you currently employed? | [ ] Yes | [ ] No |

| What is your monthly income? $ __________________________ | (This includes all household income, SSI, unemployment.) |

| What is your family size? (Includes spouse and dependents) | __________________________ |

**Health Care Information**

| Do you have health insurance? | [ ] Yes | [ ] No |

*If yes, please check all that apply:*

| [ ] Buckeye | [ ] CareSource | [ ] Molina | [ ] Paramount | [ ] United Healthcare |
| [ ] Medicaid | [ ] Medicare | [ ] MyCare Ohio | [ ] Other __________________________ |

| Do you have a primary care provider (PCP)? (A PCP is a doctor or medical provider you regularly see for your health care needs. *If yes, please provide the name of your PCP.*) | |


Do you have a regular dentist or dental care provider? (If yes, please provide the name of your dentist.)

☐ Yes: ________________________________ ☐ No

☐ Yes: ________________________________ ☐ No

AFFIDAVIT OF HOMELESSNESS

State of Ohio / County of Cuyahoga

On this date, __________________________ states: __________________________

(Please print patient name)

☐ Not Currently Homeless (do not complete below)

☐ I am currently homeless and/or I have been homeless within the last 12 months
   (please complete below)

Relationship to Patient: ☐ Self ☐ Other: __________________________

(Please specify parent/guardian/foster parent/other)

Patient/Other Signature: __________________________ Date: _______________

Witness Signature: __________________________ Date: _______________
This page is intentionally blank.
CARE ALLIANCE HEALTH CENTER – POLICIES AND PRACTICES

OUTLINED BELOW ARE THE FOLLOWING POLICIES AND PRACTICES OF CARE ALLIANCE HEALTH CENTER:

- Notice of Privacy Practices
- Patient Rights and Responsibilities
- Financial Responsibility/Policy
- Information on How to Access Services

Questions: After reviewing the information, if you have any questions about any of the policies or your rights, contact the Chief Operating Officer at (216) 781-6228 extension 227.

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

We respect patient confidentiality and only release protected health information ("PHI") about you in accordance with Ohio and federal law. Our internal policies and procedures are designed to control and protect the confidentiality and security of your personal information whether in written, oral, or electronic format. We train our employees on these policies and procedures. Employees who violate our confidentiality and security policies are subject to disciplinary action. You may also file a complaint with the Secretary of Health and Human Services if you believe Care Alliance has violated your privacy rights. No action will be taken against you as a result of filing a complaint.

NOTICE OF PRIVACY AS IT RELATES TO ELECTRONIC MEDICAL RECORDS
Care Alliance is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at http://www.community-health.org/partners.html. As a business associate of Care Alliance, OCHIN supplies information technology and related services to Care Alliance and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by Care Alliance with other OCHIN participants when necessary for health care operations purposes of the organized health care arrangement and treatment. Patient hereby authorizes the electronic transfer of information contained in a patient's medical record to specific third parties. Such authorization permits medical records to be released to the following parties: OCHIN and its members; insurance company; government agencies; health information exchange; and other health care third parties. Once the patient has given consent to release the electronic record, the disclosure requirement is valid unless a written request from the patient is otherwise received.

Care Alliance maintains an integrated electronic health record. This means that medical providers and behavioral health practitioners document necessary health information in one electronic record. Care Alliance medical providers and behavioral health practitioners routinely share relevant patient health information as it relates to treatment, payment, and health care operations.

For health information exchange (HIE): We may make your PHI available electronically through an information exchange service to other health care providers, health plans, and health care clearinghouses that request your information for treatment or payment for that treatment. Participation in health information exchange services also
provides that we may see information about you from other participants. Your participation in a HIE is subject to your right to opt-out. Where possible, you will be provided with educational information prior to the enrollment to these services.

**USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

In order to effectively provide health care, there are times when we will need to share your PHI with others outside Care Alliance. Below describes different ways that we will use and disclose your medical information. Not every use or disclosure in a category will be listed. However, all of the ways that we are allowed to use or disclose your Medical Information should fall within one of these categories:

- **Treatment.** We may share PHI about you with others to provide, coordinate, or manage your care or any related services. For example, to coordinate the different ways that Care Alliance needs to care for you, such as for prescriptions, we may need to disclose PHI to non-Care Alliance health care providers.
- **Payment.** PHI will be used to obtain payment for the treatment and services provided. This may include contacting your health insurance company for prior approval of treatment or for billing purposes.
- **Health Care Operations.** We may use information about you to coordinate certain business activities; for example, setting up appointments and reviewing your care. Care Alliance is part of an organized health care arrangement including participants in OCHIN. Your health information may be shared by Care Alliance with other OCHIN participants when necessary for health care operations purposes of the organized health care arrangement.
- **Emergencies.** Information may be shared to address the immediate emergency you are facing.
- **Follow Up Appointments/Care.** We may contact you to remind you of future appointments or to provide information about treatment alternatives or other health-related benefits and services.
- **As Required by Law.** This would include situations where we have a subpoena, court order or are mandated to provide public health information, such as information regarding communicable diseases or suspected abuse and neglect.
- **Coroners, Funeral Directors.** We may disclose PHI to a coroner, personal health examiner or funeral director for the purpose of carrying out their duties.
- **Governmental Requirements.** We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure. There might also be a need to share information with the Food and Drug Administration related to adverse events or product defects. If requested we are required to share information with the Department of Health and Human Services to determine our compliance with federal health care laws.
- **Criminal Activity or Danger to Others.** If a crime is committed on our premises or against our personnel, we may share information with law enforcement officials to assist in the apprehension of the criminal. Also, if we believe you present an immediate danger to yourself or others, we may share information with appropriate law enforcement officers.
- **Other Uses of PHI.** Other uses and disclosures of PHI not covered by this Notice or the laws that apply to Care Alliance will be made only with your written authorization. Disclosures and internal sharing of any psychotherapy notes (process notes externally maintained from your integrated health record) will be made only with your written authorization. You may cancel that authorization at any time by sending a written request to our Privacy Officer. Care Alliance is unable to take back any disclosures we have already made with your authorization.
- **Health Information Exchange.** 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 the Care Alliance.
PATIENT RIGHTS AND RESPONSIBILITIES
You have the following rights under Ohio and federal law:

- **Copy of Record.** You are entitled to inspect your personal health record unless we believe that such a disclosure could harm you or unless such disclosure is otherwise restricted. If you are denied access to any PHI, you may request that the denial be reviewed. We may charge you a reasonable fee for copying and mailing your record.

- **Release of Records.** You may request in writing to release your records to others, for any purpose you choose. This could include your attorney, employer, or others. You may revoke this consent at any time, but only to the extent that no action has been taken under your prior authorization.

- **Restriction on Record.** You may ask us not to use or disclose part of your PHI for treatment, payment, or health care operations. You also have the right to request that we disclose a limited amount of PHI to someone involved in your care or involved in payment for your care. This request must be in writing. Care Alliance is not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information.

- **Contacting You.** You may request that we provide information to another address or by alternative means. We will honor such request as long as it is reasonable. If we are unable to contact you using your requested means or locations, we may contact you using any information we have. If you have provided us with a wireless telephone number, you may receive reminders notices via voice or text messaging services unless you opt out at registration. We have a right to verify that the payment information you are providing is correct.

- **Amending Record.** If you believe that something in your record is incorrect or incomplete, you may request that we amend it. To do so, contact the Director of Human Resources and ask for the Request to Amend Health Information form. In certain cases, we may deny your request. If we deny your request for an amendment, you have a right to file a response stating that you disagree with us. We will then have a right to submit our response, and your statement and our response will be added to your record.

- **Accounting for Disclosures.** You may request a listing of any disclosures we have made related to your PHI, except for information we were required to release, we used for treatment, payment or health care operations, that we shared with you or your family, that you gave us specific consent to release, or that are otherwise excepted from being provided by law. To receive information regarding disclosures made for a specific time period, no longer than six years and after April 14, 2003, please submit your request in writing to our Privacy Officer. We will notify you if there is a cost involved.

- **Right to a Paper Copy of This Notice.** You have the right to a paper 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.

- **Changes in Policy.** Care Alliance reserves the right to change its Privacy Policy. Care Alliance reserves the right to make the revised Notice effective for PHI we already have as well as any information we receive in the future. We will post a copy of the current Notice at each Care Alliance clinic and on our website. The Notice will contain the Notice’s effective date.

FINANCIAL RESPONSIBILITY/_POLICY

If you have health insurance. Care Alliance staff will continue to file claims to your insurance company, Medicaid, or Medicare. If you have Medicare, you must pay your coinsurance as required by federal law. Your coinsurance fee may also qualify for a sliding fee discount. Care Alliance nominal fees will be waived.

Some services may not be considered eligible benefits (e.g., services and/or supplies may be determined to not be medically necessary, non-covered or investigational by my health insurance provider). Your health insurance coverage may have certain restrictions and limitations, such as authorization requirements, non-covered and frequency of service limits. Examples: Non-covered services, procedures, or drugs which are considered experimental by the US Department of Health and Human Services or another federal agency. You will be financially responsible for any and all related charges if they are not covered by your health insurance.

If you do not have health insurance. Care Alliance fees will continue to be discounted based on income and family size. You will be responsible for Care Alliance nominal fees.
**Care Alliance Sliding Fee Discount Program and Nominal Fees.**

Care Alliance is not a Free Clinic. Our ability to provide high quality, accessible services depends on our ability to collect the fees that we are required to charge.

Care Alliance is able to discount the fees we charge depending on a patient’s family size and income. This discount is applied to the charges and the patient is responsible for the remaining balance as well as nominal fees. Patients who qualify for a full sliding fee discount may still be responsible for a nominal fee for services, based on if you have insurance. Patients must provide proof of residency and income at the time of their first visit and every 12 months thereafter to calculate participation in the Sliding Fee Discount Program.

**The following are acceptable documents to show proof of income and family size:**

- 3 consecutive paycheck stubs
- IRS tax return for previous year
- Documentation of other income such as SSI/SSDI award letters, Unemployment award letter, or Worker’s Compensation award letter

**Payment is due before a patient sees a health care professional.** Care Alliance Health Center accepts cash, personal checks, MasterCard and Visa.

- *Patients who do not bring proof of income after three visits will not be allowed to schedule future appointments. Such patients will only be seen on a walk in basis.*
- *Patients who do not make payments after three visits will not be allowed to schedule future appointments. Such patients will only be seen on a walk in basis.*
As a Federally Qualified Health Center it is our mission is to make sure patients can afford the healthcare they need. That is why we offer qualified patients a **Sliding Fee Discount**.

- Our sliding fee discount is for anyone whose household income is at or below the [Federal Poverty Guidelines](#). “Household” includes all people living in the same house or apartment even if they are not related to you.

- After you fill out the Sliding Fee Scale Application we can tell you how much we can discount your fee. We can use this discount for any amount due and for any services we offer.

- Your application is considered **pending** until you receive written notice that it has been approved.

- We will give you the care you need no matter what you can pay.

**How to apply for our sliding fee discount:**

Our front desk staff can help you apply. Step one, asking about your household size and income, is always done as part of check-in.

To apply for a discount you must fill out a short form and show us proof of income. If you don’t have proof of income on your first visit, we can give you 30 days to bring in one of the documents listed below. Your application can’t be approved until we have all of the paperwork we need.

**What you need to bring for “proof of income”:**

**If you are EMPLOYED:**
- a copy of last year’s income tax return
  - OR • a W-2 (If you did not file a return)
    - OR • pay stubs from last 30 days
    - OR • written statement from your employer

**If you are NOT EMPLOYED:**
- Proof of Social Security income
- Proof of Unemployment income
- Proof of Disability income
- Proof of other income (if you have it) like child support, alimony, or pension

*We will ask you to update your Sliding Fee Application every year.*
CARE ALLIANCE HEALTH CENTER

EFFECTIVE 2018 (updated April 2018)

Care Alliance is pleased to provide services for you today on a discounted, sliding fee schedule based on your income.

Your bill for today’s service will be calculated as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>SLIDE SCALE A (0%-100% P.L.)</th>
<th>SLIDE SCALE B (101-125% P.L.)</th>
<th>SLIDE SCALE C (126%-150% P.L.)</th>
<th>SLIDE SCALE D (151%-175%)</th>
<th>SLIDE SCALE E (176%-200% P.L.)</th>
<th>SLIDE SCALE F (201% and above P.L.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>FROM $0 TO $12,140</td>
<td>FROM $12,141 TO $15,175</td>
<td>FROM $15,176 TO $18,210</td>
<td>FROM $18,211 TO $21,245</td>
<td>FROM $21,246 TO $24,280</td>
<td>FROM $24,280</td>
</tr>
<tr>
<td>2</td>
<td>FROM 0 TO 16,460</td>
<td>FROM 16,461 TO 20,575</td>
<td>FROM 20,576 TO 24,690</td>
<td>FROM 24,691 TO 28,805</td>
<td>FROM 28,806 TO 32,920</td>
<td>FROM 32,920</td>
</tr>
<tr>
<td>3</td>
<td>FROM 0 TO 20,780</td>
<td>FROM 20,781 TO 25,975</td>
<td>FROM 25,976 TO 31,170</td>
<td>FROM 31,171 TO 36,365</td>
<td>FROM 36,366 TO 41,560</td>
<td>FROM 41,560</td>
</tr>
<tr>
<td>4</td>
<td>FROM 0 TO 25,100</td>
<td>FROM 25,101 TO 31,375</td>
<td>FROM 31,376 TO 37,650</td>
<td>FROM 37,651 TO 43,925</td>
<td>FROM 43,926 TO 50,200</td>
<td>FROM 50,200</td>
</tr>
<tr>
<td>5</td>
<td>FROM 0 TO 29,420</td>
<td>FROM 29,421 TO 36,775</td>
<td>FROM 36,776 TO 44,130</td>
<td>FROM 44,131 TO 51,485</td>
<td>FROM 51,486 TO 58,840</td>
<td>FROM 58,840</td>
</tr>
<tr>
<td>6</td>
<td>FROM 0 TO 33,740</td>
<td>FROM 33,741 TO 42,175</td>
<td>FROM 42,176 TO 50,610</td>
<td>FROM 50,611 TO 59,045</td>
<td>FROM 59,046 TO 67,480</td>
<td>FROM 67,480</td>
</tr>
</tbody>
</table>

CHARGES

<table>
<thead>
<tr>
<th>Medical Visits*</th>
<th>$2</th>
<th>$10</th>
<th>$15</th>
<th>$20</th>
<th>$25</th>
<th>Full Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Visits</td>
<td>$10</td>
<td>$20</td>
<td>$30</td>
<td>$40</td>
<td>$50</td>
<td>Full Fee</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$2</td>
<td>$4</td>
<td>$4</td>
<td>$4</td>
<td>$4</td>
<td>Full Fee ^</td>
</tr>
<tr>
<td>Dentures/ Resin Partial</td>
<td>$350</td>
<td>$400</td>
<td>$500</td>
<td>$600</td>
<td>$700</td>
<td>Full Fee</td>
</tr>
<tr>
<td>Crowns (PFM, Porcelain)</td>
<td>$300</td>
<td>$400</td>
<td>$500</td>
<td>$600</td>
<td>$700</td>
<td>Full Fee</td>
</tr>
<tr>
<td>Cast Partial</td>
<td>25%</td>
<td>40%</td>
<td>55%</td>
<td>70%</td>
<td>85%</td>
<td>Full Fee</td>
</tr>
<tr>
<td>Major Dental Work** (RCT, add tooth)</td>
<td>40%</td>
<td>45%</td>
<td>55%</td>
<td>70%</td>
<td>85%</td>
<td>Full Fee</td>
</tr>
</tbody>
</table>

For families/households with more than 6 person add $4,320 for each additional member

IMPORTANT!

If you are single and your income is below $12,140 the majority of your bill will be paid with funding we receive from the Bureau of Primary Health Care, local foundations and other contributions.

*There are additional fees, based on family size and income, for devices such as Long Acting Reversible Contraception (LARC).
You will be notified in advance to discuss options, including payment.

**The charge for dentures & partials is a one-time fee. For other procedures such as crowns, bridges, root canals, etc., you will be charged a percentage of the full fee, based on family size and income.

Access to Services

Welcome to Care Alliance Health Center!

As your health care provider, we want to help you stay healthy. We can be your medical home by providing services that help keep you healthy and managing chronic health problems.

Primary medical care for all ages
- Annual physical exams (adult and child)
- Child health care
- STD testing and treatment
- Chronic disease management
- Women’s health services
- Podiatry
- Physical therapy
- Referrals to specialty care
- Pharmacy
- Integrated patient health records at all clinic sites

Dental care
- Dental Cleanings
- Extractions
- X-Rays
- Oral cancer screenings
- Restorative care including partials and dentures
- Oral surgery

Behavioral health
- Mental health assessment and counseling
- Substance abuse counseling
- Psychiatry

Supportive services & assistance
- Health care navigation and case management
- Support with Medicaid enrollment and benefit programs

Ryan White services
- Free, confidential HIV testing
- HIV/AIDS medical treatment
- Medical case management
- Health education, peer support and counseling

Outreach services
Offered at shelters, treatment centers, drop-in sites and campsites throughout the city
- Health clinics and education
- Case management

If you are sick, please call one of our clinics:
Downtown: (216) 781-6724  Central: (216) 535-9100
Eastside: (216) 923-5000  Westside: (216) 619-5571
Appointments are available daily.

Care Alliance does not deny services based on a person’s race, color, disability, religion, sex, sexual orientation, national origin, or inability to pay. We accept health insurance, including Medicaid, Medicare, and CHIP.

This health center is a Health Center Program grantee under 42 U.S.C. 254b, a deemed Public Health Service employee under 42 U.S.C. 233(g)-(n), and a deemed FTCA facility. This health center receives HHS funding and has Federal Public Health Service (PHS) deemed status with respect to certain Health or Health-related claims, including medical malpractice claims, for itself and its covered individuals.

Care Alliance Health Center is an equal opportunity employer.
Patient Rights & Responsibilities

As a patient with Care Alliance, you have the following rights and responsibilities:

You have the right to:

1. Be treated in a respectful, courteous and dignified manner in a clean and safe setting.
2. Privacy regarding your financial and personal health information.
3. Not to be discriminated against based on race, ethnicity, age, color, gender, sexual orientation, religion, disabilities or HIV infection including AIDS.
4. Have your medical condition explained to you until you are satisfied with the information provided.
5. Have your questions addressed by the Care Alliance staff in a timely manner.
6. Have your treatment choices explained to your satisfaction including a review of the benefits and the risks, including the most serious side effects and possible complications of treatment.
7. Accept or refuse any recommended treatment or therapy.
8. Know all the names and qualifications of the staff members caring for you.
9. Change providers upon request without consequence to you.
10. Raise concerns and complaints in a constructive and timely manner.
11. Be informed for the reason of termination of services.

You have the responsibility to:

1. Provide the staff with the most complete, honest information about your health now and in the past.
2. Ask questions about your medical condition and your recommended treatment until you are satisfied.
3. Report changes in your health condition to the Care Alliance staff in a timely manner.
4. Treat the staff and other patients of Care Alliance in a respectful manner without foul language and threats or violent behavior.
5. Provide accurate financial information and, when applicable, provide payment as requested.
6. Keep scheduled appointments or call to reschedule before the time of the appointment.
7. Update your address, phone number and emergency contact information whenever there is a change so we can contact you if necessary.
This page is intentionally blank.
CARE ALLIANCE CONSENT / ACKNOWLEDGEMENT

I hereby consent to authorize Care Alliance Health Center dentists, hygienists, physicians, nurse practitioners, behavioral health clinicians, other practitioners, and/or contracted and partner agency practitioners to provide medical, dental, and/or behavioral health treatment, including but not limited to: diagnostic procedures, lab testing, and administration of anesthetics and/or medications, as deemed necessary and advisable. This is to certify that I, the undersigned, consent to the performance of whatever medical, dental, and/or behavioral health procedures, including exams, x-rays, fluoride treatment, fillings, crowns, nerve treatment, extractions, and space maintenance that may be decided by myself and the attending medical, dental, and/or behavioral health provider to be necessary and advisable. I understand that the following may be inherent or potential risks for the treatment I will receive: swelling, sensitivity, bleeding, pain, infection, discoloration of the face, numbness and/or tingling sensation of the lip, chin gums, tongue, cheeks and teeth, which is temporary, but on rare occasions may be permanent reactions to injections; changes in biting; jaw muscle cramps or spasms; temporomandibular joint difficulty; loosening of teeth, crowns or bridges; referred pain to the neck, head and ear; delayed healing; sinus perforation; treatment failure, complications resulting from the use of dental instruments (broken instruments, perforation of tooth, root, sinus); and temporary anxiety or emotional trauma. With the use of any medications or anesthetics, allergies may occur. Some reactions to medication may also include drowsiness and lack of coordination. Antibiotics may inhibit the effectiveness of birth control pills. I have been given the opportunity to question the doctor or relevant health practitioner concerning the nature of treatment, the inherent risks of treatment, and the alternative to treatment, including no treatment at all. I hereby authorize the doctor, dentists, and/or other relevant care-providing associates or assistants to render medical, dental, and/or behavioral health treatment. I sign this form fully understanding its content, of my own free will, and without being subject to duress or undue influence. I also certify that I am mentally competent to give this informed consent.

I acknowledge that I have been notified of and agree to Care Alliance’s Notice of Privacy Practices, My Rights and Responsibilities, Financial Responsibility/Policy and Information on How to Access Services. I have been given a chance to review them and offered a copy. I also acknowledge that if I wish to have a copy in the future, it is available to me.

Relationship to Patient  ☐ Self  ☐ Other  [Please Specify (parent/guardian/foster parent/other)]

Patient/Other Signature________________________________________ Date__________________
Summary

• Your personal health information may be released to other healthcare professionals within the Care alliance health center, Inc. (“CAHC”) for the purpose of providing you with quality healthcare.

• Your personal health information may be released to your insurance provider for the purpose of CAHC receiving payment for providing you with needed healthcare services.

• Your personal health information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.

• Your personal health information may be released to other healthcare providers in the event you need emergency care.

• Your personal health information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).

• Your personal health information may not be released for any other purpose than that which is identified in the attached notice.

• Your personal health information may be released only after receiving written authorization from you. You may revoke your permission to release personal healthcare information at any time.

• You may be contacted by the CAHC to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.

• You may be contacted by the CAHC for the purposes of raising funds to support the CAHC’s operations.

• You have the right to restrict the use of your personal health information. However, the CAHC may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.

• You have the right to receive confidential communication about your health status.

• You have the right to review and photocopy any/all portions of your healthcare information.

• You have the right to make changes regarding the healthcare information that you have provided.

• You have the right to know who has accessed your personal healthcare information and for what purpose.

• You have the right to possess a copy of our Notice of Privacy Practices upon request. A copy of the notice will be provided in the form of a paper document.
• The CAHC is required by law to protect the privacy of its patients and guest. We will keep confidential any and all patient healthcare information and will provide patients with a list of duties or practices that protect confidential healthcare information.

• CAHC will abide by the terms of the notice. CAHC reserves the right to make changes to the notice and continue to maintain the confidentiality of all healthcare information. We will post a copy of our current notice in all of our sites. Our notice will indicate the effective date on the first page. We will also give you a copy of our current notice upon request.

• You have the right to complain to CAHC or Secretary of the Department of Health and Human Services if you believe your rights to privacy have been violated. All complaints will be investigated. No personal issue will be raised for filing a complaint with the CAHC. If you feel your privacy rights have been violated or you want further information about our Notice of Privacy Practices, please write or call CAHC privacy contact person at:

  Attn: Privacy Officer  
  Care Alliance Health Center  
  1530 St Clair NE  
  Cleveland, Ohio 44114  
  Tel. (216) 535-9100

**PATIENT/CLIENT ACKNOWLEDGMENT OF RECEIPT**

I, [First and Last Name] hereby acknowledge that I have received a copy of the Care Alliance Health Center, Inc. Notice of Privacy Practices.

<table>
<thead>
<tr>
<th>Patient/Guest Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature of Parent or Patient's/Guest's Representative (if applicable)</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Description of Legal Authority to Act on Behalf of Patient/Client</th>
<th>Date</th>
</tr>
</thead>
</table>
**DOCTORS CAN NOW SHARE MY MEDICAL RECORDS ELECTRONICALLY!**

**Automatic Consent**
You’re automatically enrolled in the Health Information Exchange so your medical records can be electronically shared among your doctors. You can opt out of the exchange by filling out the back of this form and giving it to practice staff.

**Important Information for Doctors**
Sharing records electronically is a simple, fast way for your healthcare provider to get a “whole” picture of your health in one record, no matter where you have been treated in Ohio.

**Saving Time & Lives**
This is especially important in an emergency, when you may be unconscious or unable to speak. Your doctor can save time and even your life when your medical history is right there.

<table>
<thead>
<tr>
<th>Improved Patient Safety</th>
<th>Quicker Results</th>
<th>Increased Privacy &amp; Security</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you’re away from home and in Ohio when you get sick, clinicians can view what medical problems you have and see any allergies you might have. This improves your care and your</td>
<td>When your doctor orders tests, the health information exchange quickly sends those results in real time. Your physician also can get the most up-to-date and accurate information from others who have treated you.</td>
<td>Only doctors and staff who treat you can look at your health information. Your records remain private in a secure network that is audited.</td>
</tr>
</tbody>
</table>

If you wish to opt out of the Health Information Exchange, please fill out the form on the back of this page. Thank you!
REQUEST TO CHANGE CONSENT

I understand that my treating providers have access to my medical records through the CliniSync Health Information Exchange.

If you DO NOT want to have your records shared, please mark the box below.

☐ I don't want to have my records shared on a Health Information Exchange. I understand that my test results and medical information will not be accessible to healthcare providers (including emergency room physicians) through CliniSync. I understand that I may choose to participate in CliniSync again at any time.

If you previously said you didn't want to have your records shared and NOW WANT them shared, please mark the box below. This will allow your status to be changed.

☐ I consent to have my records shared through the Health Information Exchange. I have read this form. I have had a chance to ask questions. I am satisfied with the answers.

First Name: _____________________________________________ Middle Name: _____________

Last Name: ________________________________________________

Previous Last Name: ___________________________ Date of Birth: __________________________

Gender: Male ☐ Female ☐

Street Address: ____________________________________________

City: ___________________________________ State: _________ Zip Code: __________

Phone: (_____)___________________ OR Cell: (_____)___________________________

Email Address: _____________________________________________

Social Security Number: ____________________________

Patient Signature: X ________________________________________ Date: ________________

(If under the age of 18, signature of parent or legal guardian)________________________________

You can have the information below filled out by your medical provider’s office staff, hospital or other facility so they can change your consent. OR, you can have it notarized and mail it to:

Att: Consent Status, 3455 Mill Run Dr. Ste 15, Hilliard, OH 43026

---------------------------------------------------------------------------------------------------------------

Section to be completed by a Notary Public or Medical Office:

I witnessed the above named individual sign this document and the individual is personally known to me or provided me with valid picture identification on this day ____ of _____________, 20______.

Notary or Medical Office Staff Print Name: ________________________________________________

Phone Number: __________________________

Notary or Medical Office Staff Signature: X ________________________________________________