KANIKSU
COMMUNITY HEALTH

Patient/Guardian's Printed Name: _____

Patient Consent for Use & Disclosure of Protected Health Information (PHI) *[Form HIPAA 03-a]*

By signing this form, I am consenting to allow KCH to use and disclose my PHI to carry out treatment, payment, and health care operations (TPO). The Notice of Privacy Practices provide by KCH describes such uses and disclosures more completely. I have the right to review the Notice of Privacy Practices prior to signing this consent. Kaniksu Community Health reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Attn: Kevin Knepper, CEO
Kaniksu Community Health Administration Office
POB 2160
Sandpoint, ID 83864

With this consent, KCH may call or text me at the number provided, my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others. KCH may email or mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. KCH may also fax any PHI upon my signed approval. I have the right to request that KCH restricts how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, KCH may decline to provide treatment to me. If I would like to request to change my communication preferences or decline to be contacted via text or email, I may alert the front desk at any time.

Patient or Guardian's Signature: _____ Date: _____ Relationship to Patient: _____

Cancellations, No-Show and Late Arrival *[Form PCMH 1-A 0001a]*

To help coordinate your care, please review the following instructions for scheduling appointments:

A KCH staff member will make every attempt to make a courtesy call to confirm your appointment the day previous to your scheduled appointment or on Friday for a Monday appointment. Please be aware that on the day of your appointment, you will need to arrive 15 minutes early for all routine care appointments and 30 minutes early for a new patient exam appointment. Please be sure to bring your insurance information, Medicaid or Medicare information and co-pay if covered. If you arrive more than 15 minutes late for your scheduled appointment, you may be given one of the following options: reschedule the appointment or wait until an opening in the schedule for that day will permit the previously scheduled care to be completed. If an appointment needs to be cancelled, please call the receptionist at least 24 hours in advance. Patients who fail to cancel 3 scheduled appointments in advance and do not show up will lose the privilege of scheduling appointments in advance and will only be able to schedule same day appointments. Emergency care will be available during this period. Patients may be removed from same-day status by showing up to all appointments occurring within the 12 months following their adjustment to same-day appointment status.

Please place your scheduled appointment card with the date in a visible place!

Patient or Legal Guardian's Initials: _____