



6260 E. Colfax Avenue, Denver, CO 80220  
Phone 303.962.5317 • Fax 720.372.7848

## NOTICE OF PRIVACY PRACTICES

(Please keep for your files)

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. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are, also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on the first date you fill out paper work for the Colorado Health Network Medical Clinic (CHNMC) and will remain in effect until we replace it.

### USES AND DISCLOSURES OF HEALTH INFORMATION

#### How we may use and give out your health information:

- We may use and share your health information to provide you with medical care for example; we may share your health information with other doctors, nurses, or hospitals and staff who provide care for you.

#### Treatment:

- We may use or disclose your health information to a physician or other health care provider providing treatment to you.
- We may also disclose health information for the purposes of referral to oral health care specialists, nutrition counseling, tobacco cessation or emergency care.

#### Payment:

- We may use and disclose your health information to obtain payment for services we provide, including city and state agencies.
- We may use and share your health information to get reimbursed for the services we provide to you. For example, we may send a bill to your health insurance plan, Medicaid, case managers, social workers, third party funders or you.

#### Healthcare Operations:

- We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.

#### Other disclosures:

- We do not disclose your healthcare for any other purpose.

### **Your authorization:**

- In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written or verbal authorization to use your health information or to disclose it to anyone for any purpose.
- If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.
- Unless you give us a written or verbal authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

### **To Your Family and Friends:**

- We may contact your family and friends only with your written or verbal authorization.

### **Persons Involved in Care:**

- We may disclose health information to persons involved in your care only with your written or verbal authorization.

### **Marketing Health-Related Services:**

- We will not use your health information for marketing communications without your written or verbal authorization.

### **Fundraising Purposes:**

- We will not use your health information for fundraising purposes without your written authorization.

### **Required by Law:**

- We may use or disclose your health information, when we are required to do so by law (e.g. subpoenaed).

### **National Security:**

- We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized, federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

### **Appointment reminders:**

- We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, e-mails, postcards, or letters) with your written or verbal authorization.

## **Patient Rights**

### **Access:**

You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We may charge you a reasonable cost-based fee for extensive copies.

### **Disclosure Accounting:**

You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years but not before October 19, 2018. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

## Restriction:

You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

## Alternative Communication:

You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. If you opt to communicate with Colorado Health Network Medical Clinic via Internet, you need to be advised that our site is not "secure".

## QUESTIONS AND COMPLAINTS

- If you want more information about our privacy practices, or if you have questions or concerns, please contact us.
- If you are concerned that we may have violated your privacy or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the **Colorado Department of Health and Human Services** (CDHS), or the **Department of Regulatory Agencies** (DORA).

Contact: Lili Carrillo  
Clinical Services Officer  
Telephone: 303.945-2381  
Fax: 303.832-7823  
E-mail: [Lili.Carrillo@coloradohealthnetwork.org](mailto:Lili.Carrillo@coloradohealthnetwork.org)

Contact: Colorado. Department of Health and Human Services (CDHS)  
Address: 1575 Sherman St. 8<sup>th</sup> Floor Denver CO. 80203  
E-mail: [cdhscommunications@state.co.us](mailto:cdhscommunications@state.co.us)

Contact: Department of Regulatory Agencies (DORA)  
Address: 1560 Broadway Suite #110 Denver CO. 80202



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## PATIENT RIGHTS AND RESPONSIBILITIES

Welcome to Colorado Health Network Medical Clinic (CHNMC). We provide comprehensive and integrated Medical Health Care to adults and youth in a compassionate and professional atmosphere.

### Eligibility

In order to receive services, you need to provide:

- Proof of HIV status (if applicable).
- Current lab work results encouraged but not required, list of medications, and current vaccines.
- Proof of current residency (e.g. copy of your lease, mortgage statement, or current bill that ties you to your address, such as utility, cable, home phone bill, letter from Social Security, VA or financial supporter ).
- Proof of income (One month of most recent pay stubs, most current unemployment, SSI, SSDI, Colorado Works, VA pension, retirement, most current tax return, most current checking account statements or other income paperwork (a letter from an agency or financial supporter).
- Copy of your updated photo ID ( including: driver's license, non-driver's photo ID, social security card, Social Security Award letter or VA Benefits letter).
- Copy of Medicare, CICP, Medical insurance card and/or, Health Insurance assessment form.

### Office Hours

<b>Monday</b>	10:00 a.m. - 6:30 p.m. (closed from 1:00 - 2:00 p.m. for lunch)
<b>Tuesday-Friday</b>	8:00 a.m. - 4:30 p.m. (closed from 12:00 noon-1:00 p.m. for lunch)
<b>2<sup>nd</sup> Tuesday of Month</b>	1:00 p.m. - 4:30 p.m. Saturday (same week) 9:00 a.m. - 1:30 p.m.

### Emergencies

- All patients with **life threatening Emergencies should call (911) or go to the nearest hospital.** If you have an emergency during hours of operation please call the clinic.
- All patients with non- emergencies should call the Colorado Health Network Medical Clinic after hours (Nurse Line Phone: **303-739-1356**). If your emergency cannot be handled by calling the Nurse line, you may be referred to your nearest hospital.

### Medication (Controlled, Refills and Renewals)

- Patients (**Must**) schedule an appointment for controlled medications such as (Adderall, Testosterone, and Pain Meds, etc.)
- Patient may be asked to schedule an appointment for Medication renewals.
- Patients will be asked to call pharmacy during business hours for prescription refills, Pharmacy will then request refill authorization from provider.
- Patient will be notified with a phone call to let them know that the prescription was approved and sent back to pharmacy to fill.

## Laboratory Results

- Patient will be notified of Lab results through the patient portal
  - Unless the provider needs to address any issue
- Patients that call the office wanting to know about labs and labs have not been viewed by the Medical provider
  - Patient will be notified that they have not been reviewed
  - We will take complete message for Provider
  - We will let them know that either the Medical Assistant or Medical Provider will contact them

## Medical Insurance

CHNMC will process most Medical insurance claims. If the insurance policy is exhausted, CHNMC must have proof. You may be billed for any balances not covered by your insurance plan. Please be aware that it is your responsibility to know the insurance policy limits and when you have reached the maximum coverage.

## By becoming a patient of CHNMC, you will agree to the following policies

### Courtesy Calls

I understand that if I do not receive a courtesy call, I am still responsible for keeping my scheduled appointment.

### Cancellation

- I will make all of my Medical appointments. If I have to cancel an appointment for any reason, I will call at least 24 hours before the scheduled appointment.
- If I miss three (3) appointments without calling (no show) within two consecutive years, I will be warned in writing that I have done so, this is known as a warning letter. I will not be able to schedule an appointment until the warning letter is signed.
- After receiving a written warning of missed appointments, I understand that if I miss another appointment (no show), I will be dismissed from the CHNMC practice for one year. A dismissal letter with a list of Medical clinics will be enclosed. If I have a medical emergency within 45 days of dismissal and have not located a Provider, I may be eligible to receive Medical care at CHNMC limited to an **(Emergency Consultation)** and at the discretion of the Provider.

### Fees and Charges

- I understand that any balances not covered by my insurance plan, will be my responsibility.
- I understand that I will be responsible for my co-pays.
- I understand that I cannot accumulate more than \$50 dollars in my account without pay, if I do have a greater balance an invoice will be sent to me by mail informing me of the balance owed.

### Alcohol and Drugs

- For safety reasons, I understand that if I arrive to the clinic under the influence of alcohol and/or other drugs, my appointment may be cancelled and rescheduled.

### Illness

- If I am ill, I will reschedule my appointment at least 24 hours before the scheduled appointment.
- If I become sick the day of an appointment, I will call the clinic to re-schedule my appointment. If I do not call, it will be considered a **failed appointment**.
- A 24 hour notice of cancellation to the CHNMC voice mail is acceptable.

## Lateness

- I will arrive 10 minutes before my scheduled appointment. If I cannot be on time for any reason, I will call the clinic. I understand that if I am late 15 minutes or more for my scheduled appointment, I may be re-scheduled at the Provider's discretion.

## New patients and wellness exams

- All new patient and wellness exams are schedule for one (1) hour appointment, it is imperative that you arrive on time. So that we may provide you with excellent care and good service.

## Conduct in the Clinic

- Self-respect and respect for others is a core value at the CHNMC. I understand that using and/or writing abusive language, cursing and/or yelling and/or threatening behavior towards staff, patients, and visitors or myself, will not be tolerated and **I will be dismissed from the practice.**

## Change of Address and/or Telephone Number

- I understand it is my responsibility to notify the CHNMC of any change of address or telephone number promptly.
- I understand that if I choose to no longer receive Medical care at CHNMC (**after a one (1) year period**), I must update my eligibility and go through the intake procedure with a patient services staff.

## Updating Files

- I understand that proof of residence, income, insurances, and identification must be provided bi-annually.
- I understand that if I do not provide the required information on the day of my scheduled appointment, CHNMC reserves the right to cancel and/or limit my care.

## Student and /or Contracted Provider

- I understand that CHNMC is a teaching facility.
- I understand that my treatment may be provided by a Medical Assistant (student), Medical Provider (student) or Contracted Medical Provider.

## Financial Assistance

All eligible patients receive an up-to-date copy of the **Federal Poverty Level Ranges Annually** (including new and emergency intakes). Patients of record (including emergency intakes and clinic staff), need to sign and date the proof of income, which indicates the calculations of annual income, percentage to pay for procedures and the annual cap. In order to comply with payer of last resort requirements, payment plans may be required for treatment completion. Patients will not be turned away due to inability to pay.

**I have read, and I understand and agree to the above policies.**

(These forms are also available in Spanish)

\_\_\_\_\_  
Patient or Patient Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name



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## **PATIENT GRIEVANCE POLICY**

The Colorado Health Network Medical Clinic (CHNMC) strives to bring the highest quality, compassionate Medical care to all individuals. We welcome comments on the quality of our work. If you feel you have not received adequate care and would like to take action, the following is the appropriate way in which to register a complaint:

- If the complaint is about the Medical Assistant, please ask to meet with the Clinical Operations Manager.
- If the complaint is about the Provider, please ask to see the Clinical Services Officer.
- If the complaint is about the front office staff for Clinic Matters, please ask to see the Clinical Services Officer. If the complaint is about the front office staff for operational matters, please ask to see the Clinical Operations Manager.
- If the complaint is about the Clinical Patient Navigator and cannot be resolved with her/him, please ask to see the Clinical Services Officer. If you do not have time to schedule an appointment, please put your complaint into writing. Send it to: Complaints, Colorado Health Network, 6260 E. Colfax Avenue, Denver, CO 80220. You will receive a written reply in a timely manner.

### **Waiver of Grievance Procedure**

**Any patient who is dismissed from the practice due to abusive or threatening behavior may not be entitled to a grievance procedure.**

### **Póliza de Quejas del Paciente**

La Clínica Médica de Colorado Health Network se esfuerza por brindar atención médica compasiva de la más calidad a todas las personas. Damos la bienvenida a comentarios sobre la calidad de nuestro trabajo. Si cree que no ha recibido la atención adecuada y desea tomar medidas, lo siguiente es la forma adecuada de registrar una queja.

- Si la queja es sobre el/la Asistente Médico, solicite reunirse con el Gerente de Operaciones Clínicas
- Si la queja es sobre el/la Proveedor (a), pida ver al Oficial de Servicios Clínicos.
- Si la queja es sobre el personal de la oficina principal para asuntos clínicos, solicite ver al Gerente de Operaciones Clínicas.
- Si la queja es sobre el Navegador (a) para Pacientes Clínicos y no se puede resolver con él (ella), pida ver al Oficial de Servicios Clínico. Si no tiene tiempo para programar una cita, envíe su queja por escrito y envíela a: Quejas, Colorado Health Network, 6260 E. Colfax Avenue, Denver CO 80220. Recibirá una respuesta por escrito de manera puntual.

### **Renuncia al Procedimiento de Quejas**

**Cualquier paciente que sea retirado de la Práctica debido a un comportamiento abusivo o amenazante puede no tener derecho a un procedimiento de quejas.**



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## Consent for Treatment

I agree to receive routine treatments and procedures that my medical health provider believe will help improve my health. A "routine" treatment or procedure is one that is regularly offered in an outpatient center like Colorado Health Network Medical Clinic (CHNMC). I understand that my medical health provider will work with me to diagnose and treat my health issues. Therefore, I agree to receive medicine and/or treatment that my medical health provider believes will help to diagnose and/or treat problems I am having, or improve my health and wellness.

### **Routine medical treatments and procedures at CHNMC may include:**

- Asking questions about my medical history and my health
- A physical exam
- Measuring my blood pressure, temperature, height and weight
- Prescribing and/or giving me medicine
- Having blood drawn for tests
- Other simple, common procedures

If my provider recommends any "non-routine" treatments, procedures or medicines, we will talk about that separately. I may get a special consent form for care that is non-routine that will be explained and reviewed with me by my medical or behavioral health provider.

### **I understand that:**

- CHNMC cannot promise that I will get good results from the treatment, procedures, services and medicine I receive
- My medical health provider will explain the benefits and possible risks from the routine treatment, procedures, services and medication I may receive and will tell me about other options too.
- I will have a chance to ask questions and get answers I understand about any concerns I have
- I will be able to choose the treatments, procedures, services and medicines that are suggested to me. I can choose to take some and refuse some of the treatments, procedures, services and medicines that are suggested to me.



- I can change my mind about the services I want at any time, but CHNMC cannot reverse care I have already gotten.
- If I refuse to consent to all treatment, I cannot be treated at CHNMC. Instead, CHNMC will give me referrals to other providers or health care agencies.
- I understand that my providers at CHNMC work together to provide integrated health care and to provide me the best health care experience. To do that, information about me may be shared with other necessary CHN staff involved in my care, such as my Medical Assistant, Case Manager, and Behavioral health provider.
- I understand that information I give to CHNMC is confidential and cannot be shared with anyone outside of CHNMC without my written permission except as required by law.
- I understand that CHNMC is required to report information to the State of Colorado Immunization Registry.
- I understand that CHNMC may have to share some information with outside organizations about me without my permission when any of the following things happen:
  - If CHNMC finds out about or suspects child abuse, elder abuse or abuse of someone that is disabled, it is required to report information to protect the person that may be abused.
  - If CHNMC believes that I am at a high risk of hurting or killing myself or someone else, CHNMC has to help keep me and the other person safe.

For more information about how my information can, cannot or must be shared, I can review the CHNMC’s Privacy Policies and the CHNMC’s Patient Rights and Responsibilities.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Printed Name