KCHC
KENOSHA COMMUNITY
HEALTH CENTER, INC.

Medical: 4536 22nd Avenue Kenosha, WI 53140
Phone: 262-656-0044 Fax: 262-653-2218

Dental: 6226 14th Avenue Kenosha, WI 53143
Phone: 262-656-0044 Fax: 262-925-1680

Dear Patient,

We welcome you to our clinic and are happy to have the opportunity to serve you. We pride ourselves in making your medical and dental care a pleasant experience.

Kenosha Community Health Center (KCHC) is a nonprofit organization offering comprehensive healthcare which enables our patients to maintain their well-being by addressing health disparities and providing access for all.

KCHC provides quality medical and dental services. Our medical services include family practice, obstetrics, pediatrics and behavioral health. Dental services include preventative and restorative services. KCHC also provides an on-site lab and outreach services to better serve you.

For your convenience, the hours of operation and locations are as follows:

KCHC Medical Clinic

4536 22nd Avenue, Kenosha, WI 53140
Monday – Thursday: 7:00am-7:00pm
Friday: 7:00am-5:00pm
Saturday: By appointment

KCHC Dental Clinic

6226 14th Avenue, Kenosha, WI 53143
Monday – Thursday: 7:00am-7:00pm
Friday: 7:00am-5:00pm
Saturday: 7:00am-3:00pm

We look forward to serving your needs. If you have any questions, please call our main line at (262) 656-0044.

Sincerely,

The Staff at Kenosha Community Health Center

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Date: ____________

PATIENT INFORMATION

Last Name | First Name | Middle Initial

Date of Birth | Social Security Number | Gender: Male Female

Home Address | Apt # | City | State | Zip Code

Home Phone | Work Phone | Other Phone Cell Pager Fax

Email Address

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name | First Name | Relationship to Patient

Address | Apt # | City | State | Zip Code

Home Phone | Work Phone | Other Phone

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient Self Spouse Parent Other ______________________

Last Name | First Name

Date of Birth | Social Security Number | Gender: Male Female

Home Address | Apt # | City | State | Zip Code

Home Phone | Work Phone | Other Phone Cell Pager Fax

Employer | Employer Phone

The U. S. Health Resources and Services Administration requests the following information:

Race: Black/African American | American Indian/ Alaskan Native | Asian | Native Hawaiian | Other Pacific Islander | White

Ethnicity: Hispanic/Latino YES NO | **Language best served:**

Homeless: YES NO | **Veteran**: YES NO | **Agricultural Worker:** YES NO

Number of Household Members: | **Total Gross Household Income:** Weekly Annual Monthly

HOUSEHOLD ASSESSMENT

Patient Name: ________________________________ **Date:** _________________________________

*ATTACH COPIES OF LAST TWO PAY STUBS AND/OR PROOF OF ANY INCOME SUCH AS SOCIAL SECURITY, VETERANS BENEFITS, WORKERS' COMPENSATION, PUBLIC ASSISTANCE AND/OR UNEMPLOYMENT BENEFITS FOR ALL HOUSEHOLD MEMBERS. IF YOU ARE SELF EMPLOYED SUBMIT YOUR MOST RECENT YEAR'S TAX RETURN. FAILURE TO PROVIDE COMPLETE DOCUMENTATION WILL RESULT IN SLIDING FEE NOT BEING APPLIED AND PATIENT WILL BE RESPONSIBLE FOR ALL CHARGES.

Are you or any member of your household self-employed? YES NO

If yes, please specify type of business and gross income *AND* attach a copy of last year's 1040 Tax Return:

Business: _________________________________ Income: ______________________________

List ALL household members and/or dependents (INCLUDING YOU), their ages and income:

NAME	DOB	EMPLOYED YES	EMPLOYED NO	GROSS INCOME	PER WEEK MONTH OR YEAR

PLEASE LIST OTHER SOURCES OF INCOME:

SOURCE	YES	NO	AMOUNT	PER WEEK, MNTH OR YR
Unemployment Compensation				
Social Security				
Disability Benefits				
Worker's Compensation				
Veterans Benefits				
Alimony				
Child Support				
Other: Pension, Interest, Estate/Trusts etc.				

I AGREE THAT THE ABOVE INFORMATION IS CORRECT AND ALL SOURCES OF INCOME HAVE BEEN REPORTED. I WILL REPORT ANY INCOME CHANGES AND WILL RE-APPLY EVERY SIX MONTHS EVEN IF NO CHANGES OCCUR. FAILURE TO MEET THESE CONDITIONS MAY DISQUALIFY ME FROM FUTURE KCHC FEE DISCOUNTS.

Signed: ____ Date: _______________________________

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PATIENT FINANCIAL ACKNOWLEDGMENT FORM

*Please initial by each line

Self pay discounts-

_______ Proof of current income must be received by KCHC for a self pay discount to be taken, and a household assessment form must be filled out so that a discount level can be determined. The discount level is valid for **six months** from the date of the household assessment. If a household assessment is not received within 2 weeks of the first visit, I will be responsible for the full fee.

_______ Upon approval of the household assessment and depending on my income, I will be assigned a standard co-pay amount between $20 - $65. I will be expected to pay this amount for each appointment prior to being seen by a KCHC provider. Certain services, such as dentures, bridges, crowns, and injectable medications will be discounted by 60% of the standard fee. (Please ask the Front Desk about these services.)

_______ Quest Diagnostics provides medical lab services for KCHC patients. Quest provides discounts between 20% - 100% for eligible patients based on the KCHC household assessment. Quest will bill my insurance for lab services, but I will be responsible for insurance co-pays. (Self-pay patients ineligible for a KCHC discount will be required to pay full fees to Quest for medical lab services.)

Collection Policy-

_______ For any unpaid balanced owed to KCHC, please call Plexus Health Solutions at 654-5555 to set up a payment plan. KCHC and Plexus will provide assistance in setting up an affordable plan.

_______ I must stay current on my payment plan to continue accessing services at KCHC. In the event that I do not set up and/or stay current on my payment plan, KCHC may notify me that I am on restricted status until such time that I pay my account in full.

_________________________________ Patient/Guardian Signature

_________________ Date

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,______________________________ (Patient Name) have received a copy of the Notice of Privacy Practices from the Kenosha Community Health Center, Inc.

____
Patient/Guardian Signature

____
If Guardian, describe relationship

____
Date

FOR OFFICE USE ONLY

NOTES:

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CONSENT FORM

I request that Kenosha Community Health Center, Inc., provide me and/or family member with medical/dental care. I acknowledge my responsibility to pay for that care according to the fees established. Furthermore, I authorize assignment of benefits for medical/dental service to be paid to the Kenosha Community Health Center, Inc.

Please list below all such persons KCHC may disclose your information to as described in the Notice of Healthcare Privacy Practices.

Name	Relationship	Address	Phone Number

Signature: ______________________________

Relationship: ______________________________

Date: ______________________________

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Outreach Services

In addition to providing Medical and Dental services to residents of Kenosha County, KCHC can assist patients with access to the following outreach services.

Badger Care Enrollment - KCHC will assist uninsured patients with enrollment with BadgerCare and other social service programs that include Express Enrollment, BadgerCare Plus, Core Plan, Mahone Breast and Cervical Cancer Fund, Alien Emergency Care, FoodShare, Wisconsin Well Women's Program and Family Planning Waiver.

OB Program – KCHC, together with Aurora Medical Group, offers Obstetric Care services.

Prescription Assistance Program - KCHC will assist patients, who are having financial hardship, with applying for free medications through pharmaceutical assistance programs.

Assistance for Diabetic Patients - KCHC works with United Way to provide vouchers for free exams to uninsured patients for eye exams, dental exams, and podiatry appointments. Test strips and glucose monitors can also be distributed to uninsured patients.

Mammograms and Pap Smears - KCHC will assist uninsured women between the ages of 35-64 by providing vouchers for a free Mammogram and Pap screening.

WIC - KCHC will provide contact information for services provided by Women, Infants and Children Program (WIC). WIC provides food and nutrition information to help keep pregnant, breastfeeding women, infants and children less than five years of age healthy and strong.

Housing Assistance - KCHC will provide contact information for rental, mortgage and energy programs.

Bus Transportation – KCHC has easy access for bus transportation to and from the clinic.

If you need help with any of the above services or have any additional concerns, please call 262-925-2237 or 262-925-1327 and ask for Outreach Services.
We look forward to serving you.

Sincerely,

The Staff at Kenosha Community Health Center

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Appointment Policies

- KCHC will attempt a courtesy reminder call to patients prior to their scheduled appointment. This is not an obligation of KCHC. The patient is responsible for keeping the appointment time. In case of a patient phone number change or disconnection, the patient is responsible to communicate with KCHC to confirm the appointment.

- If a patient does not confirm an appointment with KCHC, KCHC reserves the right to cancel the appointment.

- KCHC maintains a strict no-show and cancellation policy. Patients that no-show or cancel their appointment within 24 hours of scheduled appointment, may be prevented from scheduling future appointments.

- KCHC requests 48 hours notice when cancelling or rescheduling an appointment.

- KCHC requests scheduled patients bring only one companion to an appointment. A child may be accompanied by one parent. In the event that more than one person accompanies a patient, only one parent or guardian will be permitted in the exam area. All other members must remain in the waiting room.

- Patients must arrive on time for their appointments. KCHC reserves the right to not see a patient past their appointment time. Returning patients seen within the last year should arrive 15 minutes before scheduled appointment. New patients should arrive 30 minutes before scheduled appointment.

- Patients are responsible for all service charges not covered by insurance.

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ATTENTION ALL PATIENTS
NOTICE OF TWO NEW POLICIES
EFFECTIVE MAY 1, 2009

NEW FEE SCHEDULE

To keep pace with the Wisconsin market and increasing costs, KCHC medical fees will increase as of May 1, 2009. Fees for dental services will not change. This will have little or no impact on most patients. For insured patients, most co-pays remain the same as before. For uninsured medical and dental patients who qualify for sliding fee, instead of a percentage of total charges, you will be asked to pay a flat co-payment as follows:

Private Pay Plan	Federal Poverty Level %	Co-Pay
Plan A	0 – 99%	$20
Plan B	100 – 124%	$35
Plan C	125 – 149%	$45
Plan D	150 – 174%	$55
Plan E	175 – 199%	$65
Plan F	> 199%	Full Fee

With the exception of vaccines, dentures, crowns, and bridges, patients will not be asked to pay anything other than the co-pays listed above. To carry a balance, a patient must enroll in and comply with a formal payment plan.

IDENTITY THEFT PREVENTION PROGRAM

The Federal Trade Commission requires KCHC to verify every patient's identity, address, and insurance coverage. At the time of appointment, each patient will be asked to provide the following:

A. A current driver's license or other photo identification. If the photo identification does not show the patient's current address, a utility bill or other official correspondence confirming the patient's current address should be provided. (If the patient is a minor, the patient's parent or guardian should bring the information listed above.)
B. A current insurance card.
C. For the initial appointment, the patient will be asked to provide KCHC with their Social Security number. (Patients without Social Security numbers will **not** be denied services.)
D. Verify the validity of any requests for changes in billing addresses.