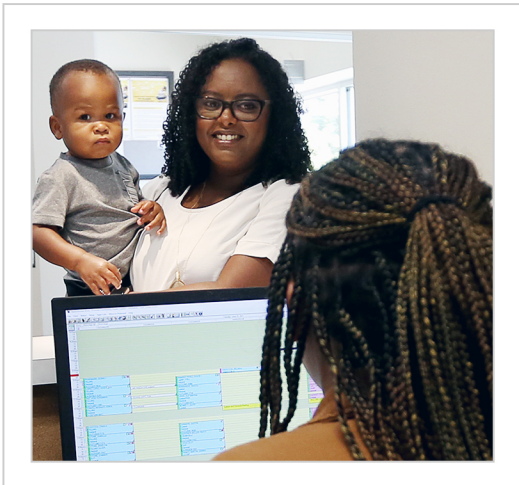


EVERYONE IS WELCOME AT PROMISE COMMUNITY HEALTH CENTER!



Promise is a community health center which means we aim to serve the whole community – any language, background, or insurance status.

If you have a lower income and no insurance, we would love to serve you and are able to offer a discount on your services. We will also support you in any other barriers to better health.

If you have insurance, we would love to serve you. By choosing Promise, you can support your community as these insurance payments can help Promise’s financial strength to continue its mission. It is a great way to partner with us as we continue to make health care available to all individuals.

PAYING FOR SERVICES INSURANCE



Promise Community Health Center will submit your claim to any private insurance company along with Medicare and Medicaid for you. The patient’s insurance information and card must be submitted at the time of service.

Promise CHC is a participating provider in many insurance plans including Medicaid, Medicare, Wellmark and many others. Patients will need to check coverage with their individual insurance plans.



- * Patients will need to check individual plan to see if in-network.
- * Promise Community Health Center does not accept any insurance discount plans.
- * Insurance plans Promise Community Health Center participates in are subject to change without notice.

If you have questions about your health plan, please contact our clinic and ask to speak with a Financial Counselor.



HEALTH INSURANCE MARKETPLACE

Health insurance plans that fit your needs and your budget can be found on the insurance marketplace. Low-cost and free plans are available, and financial help is available based on how much money you make. If you do not have health insurance or would like to see if you qualify for more affordable coverage, schedule an appointment with one of our Financial Counselors or you can visit www.healthcare.gov.

SLIDING FEE SCALE DISCOUNT PROGRAM POLICY



All patients are eligible to apply for Promise's sliding fee scale discount program. Eligibility is based on family size and income. Patients that are approved for the sliding fee discount scale are eligible for discounted services. Talk with our Financial Counselors to find out which of our payment options works best.

HOW TO APPLY

Once you become a patient at Promise Community Health Center a Financial Counselor will be available to meet with you to help you enroll in the sliding fee program. You must complete an application at the time of the visit and provide proof of income within 30 days.

WHAT IS CONSIDERED AN ACCEPTABLE FORM OF INCOME?

- Current Federal Income Tax (1040-1040 EZ Form)
- Paystubs for recent month
- Current bank statements showing direct deposit (SS,SSI,Fip,Child Support)
- Printout from office issuing payments (SS,SSI,SSD,unemployment,VA,etc)
- Pension payments, Veteran's Benefits
- Court order for alimony or child support or printout for child support payments
- Employer statement for cash wages (must include employer name, address and phone number)
- Award letter
- Letter from caregiver

FREQUENTLY ASKED QUESTIONS SLIDING SCALE FEE



What is the sliding fee discount scale? The sliding fee discount scale is a tool to determine how much patients are responsible for after receiving medical/dental care. The sliding fee scale is based on family size and income. In order to qualify for our sliding fee, the patient will need to complete an application at the time of the visit and provide proof of income within 30 days. No patient will be refused services based on their ability to pay.

Is Promise Community Health Center a Free Clinic? No, patients are responsible for a portion of the cost of their care.

Who pays for the services that are discounted? Grants and donations are received to help offset costs discounted for patient care.

Do I have to be a U.S. Citizen to apply for the sliding fee scale? No, patients do not have to be a U.S. citizen to apply for the sliding fee discount.

What if I am unemployed and have no income at all? Patients can still apply for the sliding fee program. Our financial counselors will be able to assist you with this process.

If I have insurance do I still qualify for the sliding fee discount? Yes, you will need to complete an application at the time of your visit and provide proof of income within 30 days.

When is the nominal fee due? A Nominal fee is a fixed charge or fixed percent of cost of service and does not reflect the true value of the service provided. This nominal fee is due at the time of your visit. The nominal fee will be for the office visit only. Additional charges may apply for supplies, labs, x-ray and dental surgery/rehabilitation services.



PAYMENTS ACCEPTED

Promise Community Health Center accepts cash, checks and credit cards.

For your convenience, you can also pay your bills online through your patient portal. It may be helpful to have your billing statement in front of you, as it will have the necessary information. Payments will be processed within three business days. Access the patient portal at www.promisechc.org.

Dental online bill pay is NOT available. You can pay cash, check, or credit card. Please call 712-722-1700 with any questions regarding your bill.

Cash and Check payments may be sent in the mail to the address listed below.

Promise Community Health Center
33 4th Street NW
Sioux Center, IA 51250



PAYMENT PLANS

If interested in setting up a payment plan, please contact a Financial Counselor.

Stefanie Flores - Financial Counselor - 712-722-1700 ext. 640 - sflores@promisechc.org

Jessica Mora - Financial Counselor - 712-722-1700 ext. 660 - jmora@promisechc.org

PATIENT RESPONSIBILITY

PROMISE COMMUNITY HEALTH CENTER



INDIVIDUAL'S FINANCIAL RESPONSIBILITY: My signature below indicates that I accept financial responsibility for this account and for payment of services provided to me and to my spouse and/or my dependents.

- If my insurance determines that I have not met my deductible I understand that I will be fully responsible for payment.
- I understand that I am responsible to pay my co-payment in full at the time of service if applicable.
- I understand I must provide a copy of my insurance card (Primary and Secondary if applicable).
- I understand that I am responsible to pay my sliding fee in full at the time of service if applicable.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health/dental plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the Medical/Dental services rendered to me at time of service.
- I understand and agree it is my responsibility and not the responsibility of the Provider or the Providers staff to know if my insurance will pay for any Medical/Dental service I receive. I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amount, usual and customary limit, or any other type of benefit limitation for the services I receive.
- I understand and agree it is my responsibility to know if the Provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the Provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible for all charges.

Insurance Disclaimer: A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service.

Beneficiary Agreement: I understand that my health/dental insurance company may deny or revoke payment for the services received. If my health/dental insurance company denies or revokes payment, I agree to be personally and fully responsible for payment. I also understand if my health/dental insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

Financial Assistance: I understand that there are financial assistance options available such as payment plans, sliding fee discount program, and insurance enrollment assistance. I can request meeting with a Financial Counselor to find out more about these options.

Patient/Guardian Signature: _____

Date: ____ / ____ / ____

Relationship to Patient: _____

Sign up for the Patient Portal

Promise staff can help you sign up for patient portal or you can create your account online at any time:

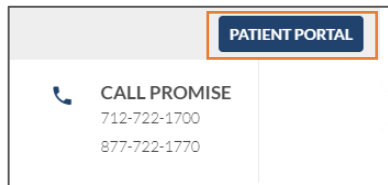
Dental Services:

Online scheduling and bill pay not available for dental services at this time.

Please contact Promise for any questions on scheduling or billing.

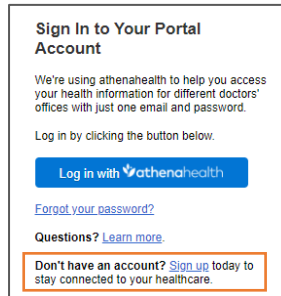
1.

Go to promisechc.org and click Patient Portal button at top of page



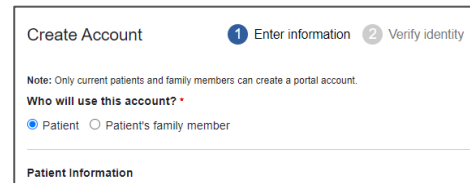
2.

Click Sign Up



3.

Set up account by entering patient information, verifying identity, and setting a password

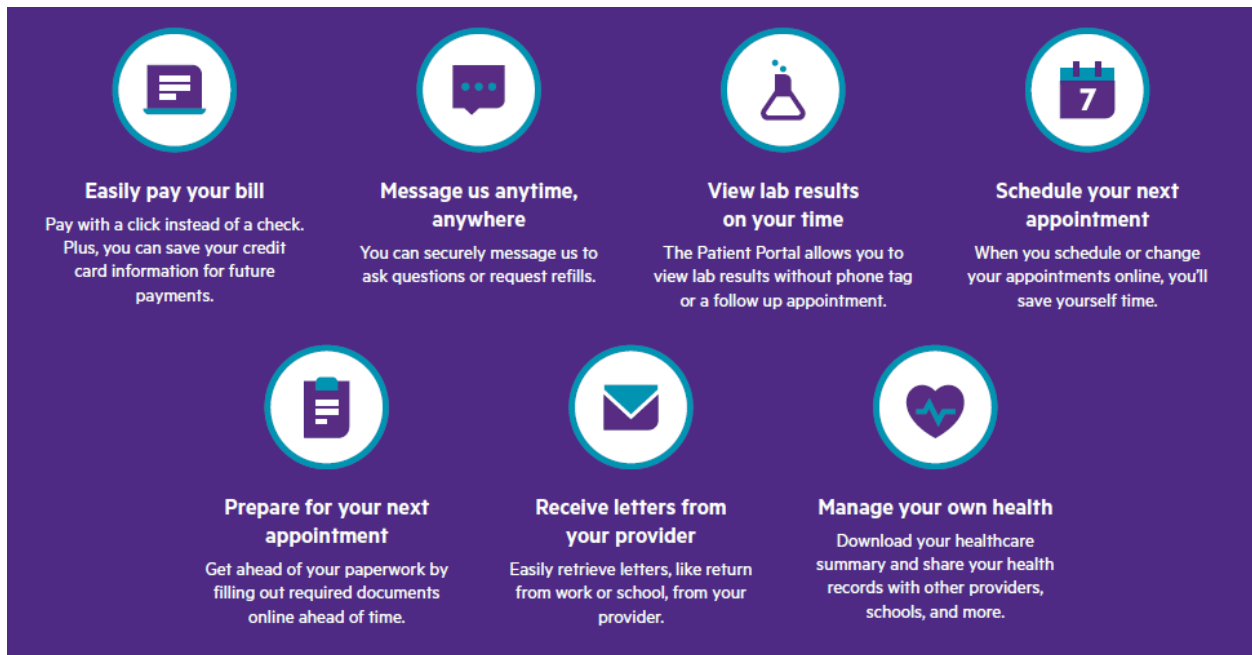


Existing patients only

Parents can have full access for children ages 0-11 and billing access only for children 12 and above.

Save the portal link: 20239.portal.athenahealth.com

Benefits of the Patient Portal



- Easily pay your bill**
Pay with a click instead of a check. Plus, you can save your credit card information for future payments.
- Message us anytime, anywhere**
You can securely message us to ask questions or request refills.
- View lab results on your time**
The Patient Portal allows you to view lab results without phone tag or a follow up appointment.
- Schedule your next appointment**
When you schedule or change your appointments online, you'll save yourself time.
- Prepare for your next appointment**
Get ahead of your paperwork by filling out required documents online ahead of time.
- Receive letters from your provider**
Easily retrieve letters, like return from work or school, from your provider.
- Manage your own health**
Download your healthcare summary and share your health records with other providers, schools, and more.



Questions? Contact Us:

care@promisechc.org

712-722-1700

Promise offers different patient paths for every patient check out some of the services offered at Promise!



EVERYONE IS WELCOME!

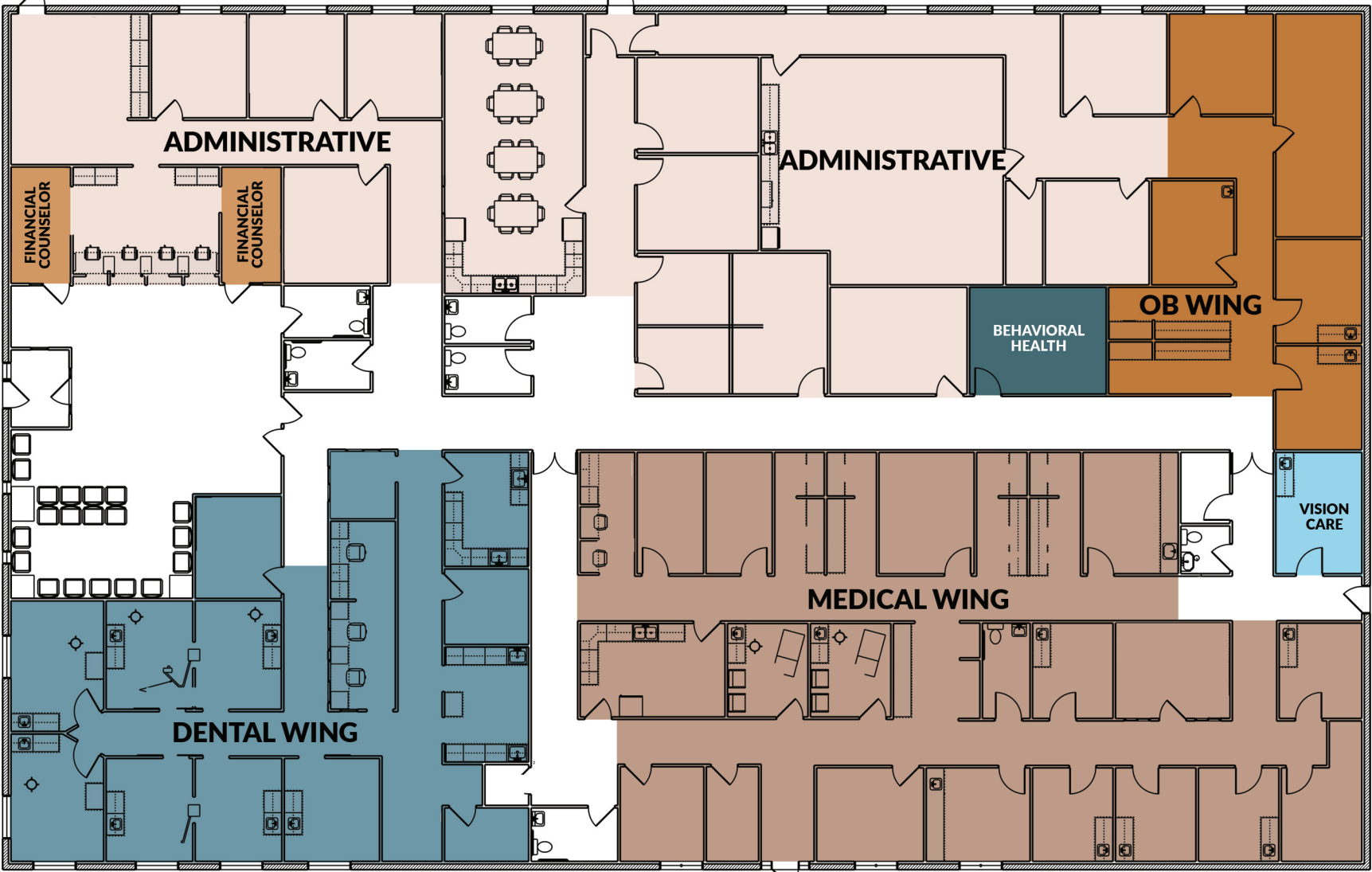
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**NORTH
MAIN ENTRANCE**

EAST



ADMINISTRATIVE

**FINANCIAL
COUNSELOR**

**FINANCIAL
COUNSELOR**

ADMINISTRATIVE

**BEHAVIORAL
HEALTH**

OB WING

DENTAL WING

MEDICAL WING

**VISION
CARE**

WEST

SOUTH


DEPARTMENT CONNECTIONS


MEDICAL



JESS KOEDAM

CLINICAL OPERATIONS COORDINATOR

 (712)722-1700 ext 485

 text (712)409-7607


 jkoedam@promisechc.org

DENTAL



BETH FABER

Dental Coordinator

 (712)722-1700 ext 670

 text (712)409-7607

 bfaber@promisechc.org

MENTAL HEALTH



MICHELLE VAN BEEK

Mental Health & Interpreting Services Coordinator

 (712)722-1700 ext 225

 text (712)409-7607

 mvanbeek@promisechc.org

VISION



JESSICA MORA

Vision Coordinator

 (712)722-1700 ext 115

 text (712)409-7607

 jmora@promisechc.org

FINANCIAL



STEFANIE FLORES

Financial Counselor

 (712)722-1700 ext 640

 text (712)409-7607

 sflores@promisechc.org

If you have questions or have a child or family you would like to refer to a certain department at Promise Community Health Center, please contact the department connections listed. Thank you!



**PROMISE
COMMUNITY
HEALTH CENTER**

**NOW OPEN SATURDAYS
8AM TO NOON**

**CALL 712-722-1700 TO
MAKE AN APPOINTMENT
INTERPRETERS AVAILABLE**

**LLAME AL 712-722-1700 PARA
PROGRAMAR UNA CITA
INTÉRPRETES DISPONIBLES**



**AHORA ABIERTO LOS SÁBADOS
8:00 AM AL MEDIO DÍA**

33 4TH STREET NW, SIOUX CENTER, IOWA 51250



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 the full Notice of Privacy Practices (NPP), which is attached. If you have any questions about this notice, please contact Emily Tuschen, CEO at (712) 722-1700 (Designated HIPAA Privacy Officer)

Your Rights

You have the right to:

- Get a copy of your health records
- Correct your health and claims records
- Get a list of those with whom we've shared your information
- Ask us to limit the information we share
- Request confidential communication
- Get a copy of this privacy notice
- File a complaint if you believe your privacy rights have been violated

Other Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Administer your health plan
- Pay for your health services
- Run our organization
- Comply with the law
- Help with public health and safety issues
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director

Our Responsibilities

We are required by law to:

- Make sure that health information that identifies you is kept private
- Let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- Give you this notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. 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 this health care practice, whether made by your personal health care provider or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. 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.

For Treatment. We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our offices, at the hospital if you are hospitalized under our supervision, or at another doctor's office, lab, pharmacy, or other health care provider to whom we may refer you for consultation, to take x-rays, to perform lab tests, to have prescriptions filled, or for other treatment purposes. 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. In addition, the doctor may need to tell the dietitian at the hospital if you have diabetes so that we can arrange for appropriate meals. We may also disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

For Payment: We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party. For example, we may need

to give your health plan information about your office visit so your health plan will pay us or reimburse you for the visit. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

As Required By Law. We will disclose health information about you when required to do so by federal, state, or local law.

To Avert 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. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans. If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

Workers' Compensation. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose health information about you for public health activities.

These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify person or organization required to receive information on FDA-regulated products;
- 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;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or 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 efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release health information if asked to do so by a law enforcement official:

- in reporting certain injuries, as required by law, (ex: gunshot wounds, burns, injuries to perpetrators of crime);
- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person:
 - Name and address;
 - Date of birth or place of birth;
 - Social security number;
 - Blood type or rh factor;
 - Type of injury;
 - Date and time of treatment and/or death, if applicable; and
 - A description of distinguishing physical characteristics.
- about the victim of a crime, if the victim agrees to disclosure or under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at our facility; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Coroners, Health Examiners and Funeral Directors. We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

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.

Protective Services for the President and Others. We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.

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 health and billing records. To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to Emily Tuschen, CEO. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies and services associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

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 for as long as we keep the information. To request an amendment, your request must be made in writing, submitted to Emily Tuschen, CEO, and must be contained on one page of paper legibly handwritten or typed in at least 10 point font size. In addition, you must provide a reason that supports your request for an amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the health information kept by or for our practice;
- is not part of the information which you would be permitted to inspect and copy; or;
- is accurate and complete.

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures. You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. To request this list of disclosures, you must submit your request in writing to Emily Tuschen, CEO. Your request must state a time period which may not be longer than six years and may not include dates before July 7, 2008. 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. We will mail you a list of disclosures in paper form within 30 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; but this date will not exceed a total of 60 days from the date you made the request.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we restrict a specified nurse from use of your information, or that we not disclose information to your spouse about a surgery you had.

We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request in writing to Emily Tuschen, CEO. In your request, you must tell us what information you want to limit and to whom you want the limits to apply; for example, use of any information by a specified nurse, or disclosure of specified surgery to your spouse.

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 to a post office box. To request confidential communications, you must make your request in writing to Emily

Tuschen, CEO. 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 a Paper Copy of This Notice. You have the right to obtain a paper copy of this notice at any time. However, at the time of first service rendered after July 7, 2008, it is required that you receive a paper copy. To obtain a copy, please request it from Emily Tuschen, CEO.

Information on how to exercise these rights can be seen in the Notice of Privacy Practices or can be obtained from Emily Tuschen, CEO at (712) 722-1700.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Emily Tuschen, CEO. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF 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 no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Acknowledgment of Receipt of this Notice

We will request that you sign a separate form or notice acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name, date. This acknowledgment will be filed with your records.