

## **REPRODUCTIVE HEALTH PROGRAM FINANCIAL AND ADMINISTRATIVE POLICIES**

Client Fees in Eastern Idaho Public Health's Reproductive Health Program are assessed based on declared household income and family unit size. The specific fees for various services are established by a program cost analysis. The fees are spread across an annually updated Poverty/Discount Index Scale (sliding fee scale). A client's income is assessed at every visit and their fee category is adjusted as needed. A copy of our financial policy is provided at each visit.

The following attachments are provided for Board of Health review and approval:

Attachment 1:	Reproductive Health Cost Analysis
Attachment 2:	Sliding Fee Scale
Attachment 3:	Reproductive Health Fees
Attachment 4:	Financial Policy
Attachment 5:	Charges, Billing, Collections Policy
Attachment 6:	Fee Collection Policy
Attachment 7:	Inventory Policy
Attachment 8:	Client Consent Form
Attachment 9:	Reproductive Health Assessment Income Sheet

Reviewed and Approved

---

Lee Staker  
Chairman, Board of Health  
Eastern Idaho Public Health

---

Date

**FISCAL YEAR July 2014/June2015 COST And Activity  
Family Planning Procedure costs**

CPT ICD9 Code	DESCRIPTION	NUMBER OF SERVICES	MINUTES PER SERVICE	TOTAL MINUTES THIS SERVICE	%OF TOTAL MINUTES THIS SERV	TOTAL COST FOR THIS SERVICE	COST FOR THIS SERVICE	Set Fee 2016
99211	Preg Test Visit	418	20	8360.00	7.85%	\$ 67,340.72	\$ 161.10	\$ 75.00
99384	Prev. Care Visit 12-17 - New	96	35	3360.00	3.15%	\$ 27,065.17	\$ 281.93	\$ 185.00
99385	Prev. Care Visit 18-39- New	565	35	19775.00	18.56%	\$ 159,289.81	\$ 281.93	\$ 195.00
99386	Prev. Care Visit 40-64- New	58	35	2030.00	1.91%	\$ 16,351.87	\$ 281.93	\$ 205.00
99394	Prev. Care Visit 12-17 - Est	40	20	800.00	0.75%	\$ 6,444.09	\$ 161.10	\$ 120.00
99395	Prev. Care Visit 18-39 - Est	787	20	15740.00	14.77%	\$ 126,787.44	\$ 161.10	\$ 130.00
99396	Prev. Care Visit 40-64 - Est	153	20	3060.00	2.87%	\$ 24,648.64	\$ 161.10	\$ 140.00
99211	IUD Check Visit	54	15	810.00	0.76%	\$ 6,524.64	\$ 120.83	\$ 80.00
99211	Counseling Visit	29	20	580.00	0.54%	\$ 4,671.96	\$ 161.10	\$ 40.00
99213	Abnormal Pap Visit	12	15	180.00	0.17%	\$ 1,449.92	\$ 120.83	\$ 80.00
99213	Infection/Problem Visit	309	15	4635.00	4.35%	\$ 37,335.44	\$ 120.83	\$ 95.00
99211	Supply Visit	1279	12.5	15987.50	15.00%	\$ 128,781.08	\$ 100.69	\$ 75.00
99212	Finish Exam	33	15	495.00	0.46%	\$ 3,987.28	\$ 120.83	
99213	IUD Removal Visit	40	20	800.00	0.75%	\$ 6,444.09	\$ 161.10	\$ 120.00
99213	IUD Insert Visit	133	20	2660.00	2.50%	\$ 21,426.59	\$ 161.10	\$ 130.00
99213	Non-Title X proplem Visit	77	15	1155.00	1.08%	\$ 9,303.65	\$ 120.83	\$ 65.00
99214	Non-Title X Annual	233	20	4660.00	4.37%	\$ 37,536.81	\$ 161.10	\$ 90.00
99211	HPV Wart Visit	115	15	1725.00	1.62%	\$ 13,895.07	\$ 120.83	\$ 75.00
36415	Blood Draw	263	7.5	1972.50	1.85%	\$ 15,888.71	\$ 60.41	\$ 35.00
81002	Urinalysis	306	7.5	2295.00	2.15%	\$ 18,486.48	\$ 60.41	\$ 32.00
85018	Hemoglobin	163	7.5	1222.50	1.15%	\$ 9,847.37	\$ 60.41	\$ 32.00
87210	Wet Mount	656	7.5	4920.00	4.62%	\$ 39,631.14	\$ 60.41	\$ 38.00
88142	Thin Prep	177	7.5	1327.50	1.25%	\$ 10,693.16	\$ 60.41	\$ 38.00
84443	Thyroid Screen (lab)	33	\$ 15.00	cost times # services		\$ 495.00	\$ 15.00	\$ 15.00
56501	Female Wart TX	15	15	225.00	0.21%	\$ 1,812.40	\$ 120.83	\$ 75.00
54050	Male Wart TX	21	15	315.00	0.30%	\$ 2,537.36	\$ 120.83	\$ 75.00
58301	IUD Removal	57	10	570.00	0.53%	\$ 4,591.41	\$ 80.55	\$ 55.00
58300	IUD Insert	119	20	2380.00	2.23%	\$ 19,171.16	\$ 161.10	\$ 110.00
	Prenatal Panel	32	\$ 40.00	cost times # services		\$ 1,280.00	\$ 40.00	\$ 40.00
	28 WK Glucola	2	\$ 5.00	cost times # services		\$ 10.00	\$ 5.00	\$ 5.00
99211	Pill Pickup	904	5	4520.00	4.24%	\$ 36,409.10	\$ 40.28	\$ 28.00
	<b>TOTALS</b>	<b>7,179</b>		<b>106,560.00</b>	<b>1.00</b>	<b>\$ 860,137.56</b>		

operating costs paid by district **848,680.00**  
 Greenway 424354 0.27 0.10 **11,457.56**  
 value of contracepives paid by State  
 FAP cost input 860,137.56  
 reduce for fixed price labs 1,785.00  
 Reduce for contraceptive supplies costs -  
**858,352.56**

# EASTERN IDAHO PUBLIC HEALTH

## Sliding Fee Scale

Effective 04/16/2015

100% of poverty is: \$11,770  
 Each additional family member is: \$4,160

Family Size	CATEGORY										
	A		B		C		D		E		F
	0%		20%		40%		60%		80%		100%
% of Poverty	100%		125%		150%		200%		250%		Greater
1	\$11,770	\$11,771	\$14,713	\$14,714	\$17,655	\$17,656	\$23,540	\$23,541	\$29,425	\$29,426	\$999,999
2	\$15,930	\$15,931	\$19,913	\$19,914	\$23,895	\$23,896	\$31,860	\$31,861	\$39,825	\$39,826	\$999,999
3	\$20,090	\$20,091	\$25,113	\$25,114	\$30,135	\$30,136	\$40,180	\$40,181	\$50,225	\$50,226	\$999,999
4	\$24,250	\$24,251	\$30,313	\$30,314	\$36,375	\$36,376	\$48,500	\$48,501	\$60,625	\$60,626	\$999,999
5	\$28,410	\$28,411	\$35,513	\$35,514	\$42,615	\$42,616	\$56,820	\$56,821	\$71,025	\$71,026	\$999,999
6	\$32,570	\$32,571	\$40,713	\$40,714	\$48,855	\$48,856	\$65,140	\$65,141	\$81,425	\$81,426	\$999,999
7	\$36,730	\$36,731	\$45,913	\$45,914	\$55,095	\$55,096	\$73,460	\$73,461	\$91,825	\$91,826	\$999,999
8	\$40,890	\$40,891	\$51,113	\$51,114	\$61,335	\$61,336	\$81,780	\$81,781	\$102,225	\$102,226	\$999,999
9	\$45,050	\$45,051	\$56,313	\$56,314	\$67,575	\$67,576	\$90,100	\$90,101	\$112,625	\$112,626	\$999,999
10	\$49,210	\$49,211	\$61,513	\$61,514	\$73,815	\$73,816	\$98,420	\$98,421	\$123,025	\$123,026	\$999,999
11	\$53,370	\$53,371	\$66,713	\$66,714	\$80,055	\$80,056	\$106,740	\$106,741	\$133,425	\$133,426	\$999,999
12	\$57,530	\$57,531	\$71,913	\$71,914	\$86,295	\$86,296	\$115,060	\$115,061	\$143,825	\$143,826	\$999,999

3.11.2015 revised GR/JH

# REPRODUCTIVE HEALTH FEES FY 2016

## TITLE X SERVICES AS OF 01/01/2016

<b>VISITS</b>	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>	<b>F</b>
Pregnancy Test Visit	\$0	\$15	\$30	\$45	\$60	\$75
Prev Care 12-17 Initial	\$0	\$37	\$74	\$111	\$148	\$185
Prev Care 18-39 Initial	\$0	\$39	\$78	\$117	\$156	\$195
Prev Care 40-64 Initial	\$0	\$41	\$82	\$123	\$164	\$205
Prev Care 12-17 Annual	\$0	\$24	\$48	\$72	\$96	\$120
Prev Care 18-39 Annual	\$0	\$26	\$52	\$78	\$104	\$130
Prev Care 40-64 Annual	\$0	\$28	\$56	\$84	\$112	\$140
Sports Physical	\$30	\$30	\$30	\$30	\$30	\$30
IUD Check	\$0	\$16	\$32	\$48	\$64	\$80
Counseling Visit	\$0	\$8	\$16	\$24	\$32	\$40
Abnormal Pap Visit	\$0	\$16	\$32	\$48	\$64	\$80
Problem Visit New	\$0	\$21	\$42	\$63	\$84	\$105
Problem visit Established	\$0	\$19	\$38	\$57	\$76	\$95
Nurse Supply Visit	\$0	\$15	\$30	\$45	\$60	\$75
IUD Removal Visit	\$0	\$24	\$48	\$72	\$96	\$120
IUD Insert Visit	\$0	\$26	\$52	\$78	\$104	\$130
Diaphragm Visit	\$0	\$15	\$30	\$45	\$60	\$75
Pill Pick up	\$0	\$5.6	\$11.2	\$16.8	\$22.4	\$28
<b>PROCEDURES</b>						
Urinalysis	\$0	\$6.4	\$12.8	\$19.2	\$25.6	\$32
Hemoglobin	\$0	\$6.4	\$12.8	\$19.2	\$25.6	\$32
Wet Mount	\$0	\$7.6	\$15.2	\$22.8	\$30.4	\$38
Pap Processing Fee	\$0	\$7.6	\$15.2	\$22.8	\$30.4	\$38
IUD Removal	\$0	\$11	\$22	\$33	\$44	\$55
IUD Insert	\$0	\$22	\$44	\$66	\$88	\$110
Diaphragm Fit	\$0	\$13	\$26	\$39	\$52	\$65
Blood Draw	\$0	\$7	\$14	\$21	\$28	\$35
Processing Fee-w/ct/gc, and hsv culture (Specimen handling)	\$0	\$2	\$4	\$6	\$8	\$10
<b>LABS</b>						
OraQuick HIV Test	\$0	\$3	\$6	\$9	\$12	\$15
Chlamydia / Gonorrhea	\$0	\$2.4	\$4.40	\$6.60	\$8.80	\$11
Hepatitis B Core AB, Total	\$0	\$2	\$4	\$6	\$8	\$10
Hepatitis B Core IgM Antibody	\$0	\$2	\$4	\$6	\$8	\$10
Hepatitis B Surface Antigen	\$0	\$2	\$4	\$6	\$8	\$10
Hepatitis C	\$0	\$2	\$4	\$6	\$8	\$10
Herpes I & II - Blood Test	\$0	\$6.20	\$12.40	\$18.60	\$24.80	\$31
Herpes I & II - Culture	\$0	\$5.80	\$11.60	\$17.40	\$23.20	\$29
HIV, Gen 4 Test - Blood Test	\$0	\$1	\$2	\$3	\$4	\$5
Syphilis (VDRL)	\$0	\$0.80	\$1.6	\$2.4	\$3.2	\$4
Thyroid Screen	\$15	\$15	\$15	\$15	\$15	\$15
Prenatal Panel	\$40	\$40	\$40	\$40	\$40	\$40
28 Wk. Glucola, CBC,	\$5	\$5	\$5	\$5	\$5	\$5
<b>SUPPLIES</b>						
Oral Contraceptives	\$0	\$1.2	\$2.4	\$3.6	\$4.8	\$6
Emergency Contraceptives	\$0	\$1	\$2	\$3	\$4	\$5
Condoms	\$0	\$0.40	\$0.80	\$1.2	\$1.6	\$2
IUD Paraguard	\$0	\$46.6	\$93.2	\$139.8	\$16.40	\$233
DMPA (Depo Provera)	\$0	\$5.4	\$10.8	\$16.2	\$21.6	\$27
Pregnancy Test Kit	\$0	\$0.20	\$0.40	\$0.60	\$0.80	\$1
IUS Mirena	\$0	\$63.6	\$127.2	\$190.8	\$254.4	\$318
IUS Liletta	\$0	\$10	\$20	\$30	\$40	\$50
Nuvaring	\$0	\$3	\$6	\$9	\$12	\$15
Doxycycline	\$51	\$51	\$51	\$51	\$51	\$51
Flagyl – 4	\$5	\$5	\$5	\$5	\$5	\$5
Metro Gel	\$5	\$5	\$5	\$5	\$5	\$5
Flagyl – 14	\$10	\$10	\$10	\$10	\$10	\$10
Bicillin	\$10	\$10	\$10	\$10	\$10	\$10
Rocephin	\$5	\$5	\$5	\$5	\$5	\$5
Zithromax	\$10	\$10	\$10	\$10	\$10	\$10

**Contributions accepted at any fee level.**

SCMAN FEE 2016- GR/jh Board approved (insert approval date)



## REPRODUCTIVE HEALTH PROGRAM

### FINANCIAL POLICY

Thank you for using us as your medical provider. Fees for our services are on a sliding fee scale based on your income and household size where applicable. You are expected to pay this fee at the time of service. **Some health services received at Eastern Idaho Public Health are not billable to insurance, Medicaid, or Medicare, and are your responsibility.**

#### SUMMARY:

- Payment is expected at the time of service.
- We accept cash, check, and Visa or Master Card for payment.
- All balances must be paid within six months.
- **Failure to make regular monthly payments will result in your account being sent to collections.**
- Donations are appreciated for all services.
- Your account status does not affect your ability to receive service.

#### HEALTH INSURANCE FACTS:

- Clients that have seen an Advanced Clinician within the last three years can have Eastern Idaho Public Health bill their insurance for Reproductive Health services.
  - **Visits with a Public Health RN or LPN prior to being seen by an Advanced Clinician are not billable to private insurances or Medicaid and are the client's responsibility.**
- Insurance payments will come directly to Eastern Idaho Public Health. Please notice that when insurance gets billed, the policy holder gets a notice of benefits at his/her address. If the patient and policy holder are not the same then total confidentiality cannot be guaranteed.
- If your insurance has not paid your account in 60 days, you will be billed.
- Please be aware that some, or perhaps all, of the services provided may not be considered reasonable and necessary under your medical insurance program. Some insurance programs have preferred medical providers (PPOs). Eastern Idaho Public Health **is not** a Preferred Provider for all insurances. If you are enrolled in a PPO and choose to have Eastern Idaho Public Health provide services, anything not covered will be **your** responsibility.
- Eastern Idaho Public Health contracts with public and private laboratories for services. You may receive a bill or insurance statement directly from our contracted laboratory for services performed.



## PROGRAMA DE SALUD REPRODUCTIVA

### POLITICA FINANCIERA

Gracias por elegirnos como su proveedor medico. Los cargos por nuestros servicios prestados son basados en sus ingresos anuales, siempre y cuando sean aplicables. Esperamos que pague los cargos después de que los servicios se le hayan sido proveídos. **Algunos servicios de salud recibidos en Eastern Idaho Public Health no son facturados a Compañías de Seguros, Medicaid, o Medicare; por lo tanto son su responsabilidad.**

#### Compendio:

- Pago es esperado en el momento que se prestan los servicios.
- Aceptamos efectivo, cheques, y solamente las tarjetas de créditos de Visa y Master Card.
- Todos los saldos (deuda) deben de ser pagados dentro un plazo de seis meses.
- **Falla en el pago regular de sus pagos mensuales resultara en el envío de su cuenta a compañías de colección.**
- Donaciones son altamente apreciadas por todos los servicios.
- El estatus de su cuenta no afecta su habilidad para recibir cualquier servicio.

#### ACERCA DE SEGUROS MEDICOS:

- Los clientes que han sido vistos por nuestro personal médico durante los últimos 3 años, pueden autorizar y designar al Eastern Idaho Public Health para cobrar a sus compañías de seguros por servicios de salud reproductiva. Las visitas con la Enfermera Registrada (RN) antes de empezar a ser vista por el personal médico, no se pueden cobrar ni a las compañías de seguro o Medicaid, por lo tanto son responsabilidad del cliente.
- Los pagos de las compañías de seguros vienen directamente a Eastern Idaho Public Health. Por favor note que, cuando las compañías de seguros reciben un cobro el Asegurado también recibe una notificación de sus beneficios en su dirección domiciliar. Si el paciente y el asegurado no son los mismos, la completa confidencialidad no puede ser garantizada.
- Si tu compañía de seguros no ha pagado después de 90 días, la factura se te enviara a ti.
- Por favor, sepa que algunos o todos servicios provistos puede que no sean cubiertos o no sean considerados razonables y necesarios bajo el programa de su seguro medico. Algunas compañías de seguros tienen Proveedores Médicos Preferidos. Eastern Idaho Public Health no es ningún Proveedor Medico Preferido de todas las compañías de aseguransas. Si tu compañía de seguros tiene esa política, y aun asi escoges tener a Eastern Idaho Public Health como tu proveedor del cuidado de tu salud, todo lo que no sea cubierto por tu compañía de seguros será tu responsabilidad.
- Eastern Idaho Public Health contrata con publico y laboratorios privados por servicios. Puede que recibas una factura o un estado de cuenta directamente de nuestro laboratorio contratado por servicios hecho.

## REPRODUCTIVE HEALTH PROGRAM

### POLICY: CHARGES, BILLING, & COLLECTIONS

#### Costs and Charges

- Charges will be based on a cost analysis completed annually or at least every three years.
- Charges will be equal to or less than the cost indicated by the analysis.
- Costs included in the analysis will be costs coded directly into the reproductive health activity code that the Family and Community Health Services Division Director and Nurse Manager consider reasonable and necessary for the operation of the program plus the allocable indirect costs.
- Charges will be periodically reviewed with the Board of Health for approval.
- Charges for all Title X related services provided to clients will vary based on the client's income per EIPH's sliding fee schedule. Other non-Title X services provided to the client may be charged at full fee.
- A schedule of discounts will be built to slide the charge amount based on the client's income.
- Charges for individuals at or below 100% of the poverty level will be zero. (Title X)
- The charges will then be slid with set points at 125%, 150%, 200% and 250% until individuals at the 250% level are paying the total calculated charge.
- The Federal Poverty Guideline Index will be applied to fees upon release by the U.S. Department of Health and Human Services (often by February).

#### Income Determination

- Client income determination will be completed by the intake clerical staff.
- Use "Reproductive Health Care Income Sheet" form to calculate client income. Intake clerical staff will input the income level calculated into the client management software. Note: income determinations for minors who receive confidential services are based on the income of the minor.
- If an individual in B-F categories is not able to pay and requests service fees be waived, the individual will have to be interviewed by the Family and Community Health Services Division Director or in case of his absence, the Nurse Manager. Substantiation of inability to pay may be requested. The hardship will be evaluated on a case-by-case basis. The Division Director or Nurse Manager may waive the fees based on their evaluation of the hardship.
- Client income is verified and re-evaluated at each visit.

#### Billing

- When a client exits, he/she will be presented a bill. This bill will show total charges less any allowable discount. Any payments made at the point of exiting will be receipted to the client before they leave.
- Third party billings will be submitted before requesting payment from the client. Responsible third parties will be billed for the full fee amount. Any remaining balance after third party payments are posted will be billed to the client based on the sliding fee schedule discounts for the individual client.

## **POLICY: CHARGES, BILLING, & COLLECTIONS (Continued)**

### Collections

- Clients are presented a copy of Eastern Idaho Public Health Financial Policy when they check in for their appointment.
- All clients will be informed of the service cost they are responsible for at the time they are exiting the office. If they are unable to pay in full, clerical staff will set up a payment plan over six months for the balance remaining.
- Clients in the sliding fee scale “A” category at the time of service will not be billed (Title X). They may make a donation at the time of service, as is the case with all other category levels. Services will not be based on the individual’s ability to make a donation in any category level.
- Clients designated as “Misty,” no notice, or less than 18 years of age with no designated responsible party noted will not be mailed a bill. They will be informed of the amount they are responsible to pay based on their own income. If they cannot pay in full at the time of service they should be encouraged to make payments without us billing them until they pay off the bill.
- Balances of \$10 or more and over 120 days with no payment in the last 30 days get sent to collections. “Misty” clients are not sent to collections.
- Client confidentiality will be maintained throughout the billing process.
- No client will be denied services for inability to pay.



## REPRODUCTIVE HEALTH PROGRAM

### FEE COLLECTION POLICY

#### APPOINTMENTS

- When making appointments clients should be told that we are a fee-for-service agency. Eastern Idaho Public Health (EIPH) accepts cash, checks or credit cards. EIPH's Reproductive Health charges are based on a sliding fee scale.
- Reproductive Health clients should be reminded they will be asked to complete an income sheet at the time of each appointment. Clients making a Reproductive Health appointment should be asked to bring some form of income verification such as check stub, income tax forms, or a record or statement of income by an accountant or other means.

#### ENCOUNTERING

- Client income is determined by completing client income sheet. The income verification documents should be used to help the client accurately figure their income which is documented in Success EHS.
- If the client fails to bring any form of income verification, they are to be assisted as accurately as possible to determine current income status and should be reminded to bring income verification at the next visit. However, services will not be denied based on the client's inability to produce income verification upon encountering. "No Income" clients may be asked to sign a "No Income" form.
- Client will be told that EIPH is a fee-for-service agency and that Reproductive Health charges are based on a sliding-fee scale according to income.

#### REPRODUCTIVE HEALTH NURSE - EXIT INTERVIEW

- Income is verified and recorded in the client electronic medical record at every visit prior to service rendered.
- Client is informed of any services that are a mandatory pay. The nurse confirms that the client agrees to pay prior to receipt of mandatory pay services.

#### EXITING STATION (This includes STD and all other clients with a previous outstanding balance)

- Check out information is entered into Success EHS and fee for services is determined.
- Reproductive Health clients are told what the actual fees are, the amount of charges EIPH/Title X has absorbed according to the sliding fee scale, and how much the client is being charged.
- The client is informed of current amount owed (including any previous outstanding balances) and asked how they prefer to pay at this time, using cash, check, or credit/debit card.
- The client is told that any remaining balance will be set up on a six-month payment plan and that we anticipate that the balance will be paid off in that six-month period. If they have not received a Financial Policy Statement, one will be provided to them at this time.
- A monthly payment plan is entered into the system.
- Clients who are paying monthly and return for services will have their new outstanding balance and six month payment plan recalculated.
- If the client disagrees with their payment plan they should be instructed to contact EIPH's billing clerk to discuss other options and be given a card with the Idaho Falls office telephone number.
- Clients are given a receipt for the day's services and payment.



## REPRODUCTIVE HEALTH PROGRAM

### POLICY: MONTHLY INVENTORY OF PHARMACEUTICALS

**PURPOSE:** Accuracy and accountability of all pharmaceuticals supplied to clientele and in each clinic site.

**POLICY:**

- All pharmaceuticals are delivered to the main office in Idaho Falls and entered into Supply Pro, the district's current inventory tracking system.
- All pharmaceuticals will be maintained in a locked area or cabinet inaccessible to clients.
- All received pharmaceuticals will be verified by two people (Reproductive Health Office Specialist and Clerical Supervisor or other designated staff member).
- The Reproductive Health Supervisor and Reproductive Health Coordinator will be responsible for ordering contraceptives from the state on the order form generated by the state office.
- The Reproductive Health Coordinator and Administrative Assistant will be responsible for obtaining antibiotics and other supplies utilized for STD treatment by the Reproductive Health program.
- The Idaho Falls staff will be responsible for the purchase of Normal Saline, Potassium Hydroxide, and Trichloroacetic Acid utilized within the program. **EXCEPTION:** Staff from the Salmon office will purchase these supplies for the Salmon and Challis offices.
- Each clinic site will be responsible for maintaining and supplying the pharmaceuticals listed in the current formulary.
- Physical counting of product will occur on the last working day of each month by two office personnel. This task is the responsibility of the Reproductive Health Coordinator and Reproductive Health Office Specialist in the main office and in the outer offices this task is the responsibility of the Senior Nurse and Office Specialist. These counts are performed in every office where product is kept on the premises.
- At the end of the month, each clinic is responsible for submitting to the Idaho Falls office an accurate inventory of all medication they currently have. The inventory should be submitted on the Monthly Inventory Sheet and include lot number, expiration dates, number they have on hand, number used and amount needed to restock. The inventory reconciliation form for Reproductive Health will have the signatures of the two staff counting the pharmaceuticals.
- Each office will maintain a record of pharmaceuticals received. This information will be entered into Supply Pro inventory system. Information needed to complete this task is the drug/device, lot number, and expiration date of the product.
- There are two options for ordering supplies:
  - Request the amount needed on the monthly inventory form or
  - Submit a Family Planning Supply Order Form to the main office.
- Once the district inventory is complete, the Reproductive Health Coordinator and the Reproductive Health Office Specialist will review and sign off on the month's district inventory and an electronic copy of Title X supplies will be sent to the State Title X Program.
- Completed Supply Inventory sheets will be maintained according to the Record Retention Policy.

# Client Consent Form -- Eastern Idaho Public Health (EIPH)

## FINANCIAL

The cost of a billable service is the responsibility of the client/guarantor. Regular monthly payments in any amount are accepted to keep accounts from going to a collection agency. For unpaid balances a payment plan can be arranged with the clerical staff.

By signing, I consent to third party billing, including payment of government benefits to EIPH, and understand that services eligible for a sliding fee will be billed at 100% to third party payors.

**Insurance** (if applicable): As a courtesy, EIPH will bill your primary insurance for some services; however, ***EIPH is not a preferred provider for all insurances.*** It is recommended that you check with your health insurance regarding coverage. Client/guarantor will be billed for any remaining balances after insurance has been processed.

**Medicare** (if applicable): EIPH will bill Medicare for flu and pneumonia vaccinations. All other vaccines are the responsibility of the client.

## TREATMENT AND VACCINES

Healthcare at EIPH may be provided by a physician, physician assistant, nurse practitioner, licensed nurse, or other qualified professional. By signing below, I consent to examination, testing (including HIV rapid testing), and treatment. I also understand that I have the right to have my questions answered and the right to refuse any procedures or tests.

I understand that immunizations are not mandatory and may be refused on religious or other grounds without reprisal. I understand information regarding vaccine(s) is available to me at EIPH. I understand the benefits and risks of vaccine(s) and ask that vaccine(s) be given to me or the person for whom I am authorized to make this request.

I understand participation in and withdrawal from the immunization registry is voluntary. If you want to opt out or withdraw from Idaho's immunization registry (IRIS), call the Idaho Immunization Program at 208.334.5931.

I understand that in order to prevent injury from falling due to post-vaccination fainting, it is recommended that I sit in the lobby for 15 minutes before exiting the building.

I authorize the release of my or my minor child's (until 18 yrs.) immunization records to clinics, physician offices, daycares and school. My authorization rights are available to me in EIPH's Notice of Privacy Practices.

## HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)/PRIVACY PRACTICES

EIPH is required by law to maintain the privacy of your health information. Your information will be used for the purpose of treatment, payment, and EIPH business. You may request a copy of EIPHD's privacy practices at any time. Individuals who pay in full and out of pocket for an item or service may request that their protected health information is not shared with their health insurance or health plan.

If you believe your privacy rights have been violated, you may file a written complaint to the Secretary of the Department of Health and Human Services or to:

Privacy Officer: Eastern Idaho Public Health  
1250 Hollipark Drive  
Idaho Falls, ID 83401

## SIGNATURE

By signing below, I confirm that I have:

- Read and understand the above information;
- Been offered a copy of EIPH's HIPAA Privacy Practices;
- Been offered a copy of EIPH's Financial Policy, and
- Been offered Vaccine Information Statements (if applicable).

Signature	Date

DOB \_\_\_\_\_  
Created 1/2013 Revised 2/2015

## Formulario de Consentimiento Eastern Idaho Public Health (EIPH)

### FINANCIAL

El costo de un servicio facturable es la responsabilidad del cliente/garante. Pagos mensuales y de cualquier cantidad son requeridas para prevenir que la factura pase a una agencia de cobros. Para saldos pendientes de pago un plan de pago se puede arreglar con el personal de oficina.

Al firmar abajo, doy mi consentimiento para facturación a terceros, incluyendo el pago de los beneficios del gobierno a EIPH, y entiendo que los servicios elegibles para los honorarios móviles se facturarán al 100% a los pagadores de terceros.

**Seguro Médico** (si aplica): Como una cortesía, EIPH facturará a su seguro médico primario para algunos servicios, sin embargo, **EIPH no participa en PPO, HMO, o planes de proveedores preferidos.**

**Planes de Proveedores Preferidos.** Se recomienda que usted consulte con su seguro de salud con respecto a la cobertura. Cliente/garante se le cobrará por cualquier saldo restante después de que el seguro ha sido procesado.

**Medicare** (si aplica): EIPHD facturará a Medicare por las vacunas contra la gripe y la neumonía. Otras vacunas serán la responsabilidad del cliente.

### TRATAMIENTO Y VACUNAS

El cuidado de salud en EIPH puede ser proporcionado por un médico, asistente médico, enfermera, enfermera con licencia, o un otro profesional calificado. Al firmar abajo, doy mi consentimiento para el examen y las pruebas (incluyendo pruebas de VIH rápido), y el tratamiento. También entiendo que tengo el derecho de tener respuestas a mis preguntas y el derecho de rechazar cualquier procedimiento o pruebas.

Entiendo que las vacunas no son obligatorias y pueden ser rechazadas por motivos religiosos o de otro tipo, sin exponerse a represalias. Entiendo que la información sobre la vacuna(s) está disponible para mí en EIPH. Entiendo los beneficios y riesgos de la vacuna(s) y pido que la vacuna(s) se dé a mí o a la persona para quien estoy autorizado para hacer la solicitud.

Entiendo que la participación y la retirada del registro de vacunación son voluntarias. Si usted no desea participar o retirarse del registro de inmunización de Idaho (IRIS), llame al Programa de Inmunización al 209-334-5931

Entiendo que para evitar lesiones debidas a caídas de desmayos después de vacunación, se recomienda sentarse en el vestíbulo por 15 minutos antes de salir del edificio.

Yo autorizo que den archivos de vacuna sobre mí y mi hijo(a) menor (hasta 18 anos) a clínicas, oficinas de médico, guarderías y escuelas. Mis derechos de autorización son disponible a mí en el EIPH's Aviso de Prácticas de Privacidad.

### HEALTH INSURANCE PORTABILITY Y ACCOUNTABILITY ACT (HIPAA) PRACTICAS DE PRIVACIDAD

EIPH está obligado por ley a mantener la privacidad de su información médica. Su información se utilizara para el propósito de tratamiento, pago, y las operaciones de EIPH. Usted puede solicitar una copia de las prácticas de privacidad EIPH en cualquier momento. Las personas que pagan en totalidad y de su bolsillo para un artículo o servicio, podrán solicitar que su información de salud protegida no sea compartida con su seguro médico o plan de salud.

Si usted cree que sus derechos de privacidad han sido violados, usted puede presentar una queja por escrito al Secretario del Departamento de Salud y Servicios Humanos a:

**Oficial de Privacidad  
Eastern Idaho Public Health  
1250 Hollipark Drive  
Idaho Falls, ID 83401**

Firma de Cliente o Representante Autorizado	Fecha

### FIRMA

Al firmar abajo, confirmo que: Leí y comprendo la información arriba; Me han ofrecido una copia de HIPAA EIPH de Practicas de Privacidad; Me han ofrecido una copia de la póliza financiera de EIPHD, y; Me han ofrecido información sobre la vacuna (si es aplicable).

DOB \_\_\_\_\_

# Reproductive Health Assessment Income Sheet

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone Number \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Emergency Contact Phone Number \_\_\_\_\_

May we contact you by phone or mail at your home? Yes  No

1. What is your **hourly pay**? \$ \_\_\_\_\_ On average, how many hours do you work **per week**? \_\_\_\_\_
2. What is your live-in partner's **hourly pay**? \$ \_\_\_\_\_ On average, **how many hours** does your partner, living with you, work **per week**? \_\_\_\_\_
3. Do you or your live-in partner receive **tips**? Yes  No  If yes, how much **per week**? \$ \_\_\_\_\_
4. Do you or your live-in partner get paid by **salary or commission**? Yes  No   
If yes, **how much**? \$ \_\_\_\_\_ **How often**? Weekly  Monthly  Annually
5. Do you or your live-in partner receive income from **SSI, disability, unemployment, family aid, or alimony**? Yes  No   
If yes, **how much**? \$ \_\_\_\_\_ **How often**? Weekly  Monthly  Annually
6. Do you have other household income? If yes, **how much**? \$ \_\_\_\_\_ **How often**? Weekly  Monthly  Annually

**\*\*DO NOT LEAVE BLANK\*\***  
**\*\*DO NOT PUT ZERO\*\***

7. Please indicate the number of people living in the household **supported** by this income: \_\_\_\_\_

8. Mark the **Race/Races** that identify you:

White  Black/African American  American Indian/Alaskan Native  Asian  Hawaiian/Pacific Islander  Other  Not Reported/Refused

9. Do you consider yourself **Hispanic or Latino**? Yes  No

10. Do you have insurance or Medicaid? Medicaid  Private Insurance  No Insurance

## Consent

- Since some medical conditions may affect my care, it is my responsibility to give as complete and accurate a medical history as possible. If new problems that may be related to my condition or care arise, I understand I should inform the clinic. I understand that it is my responsibility to seek care elsewhere for any other medical problems beyond what is provided by the clinic.
- I understand that I have a right to refuse any procedures or services *including Rapid HIV testing*, that are recommended. Refusing some types of care will not jeopardize my receiving appropriate care for other problems or concerns.
- I know that all services provided by the clinic are confidential. I understand that the results of some tests for sexually transmitted infections and other diseases must be reported to the Health Department in a confidential manner, as required by law.
- Our services are confidential; however, if you are under the age of 18 and share with us a history of sexual or physical abuse or neglect, we are required by law to report this to the Department of Health & Welfare. Please ask us if you have any questions about these laws.

The undersigned has read, fully understands, and agrees to all of the above provisions and information in this document.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Official Use Only

Verified Proof of Income: Pay Stubs  Taxes  Bank Statement  Letter of Benefits

Comments:

---

---

---

---

## Evaluación de Ingresos de Salud Reproductiva

Nombre \_\_\_\_\_ Fecha de Nacimiento \_\_\_\_\_

Dirección \_\_\_\_\_ Código Postal \_\_\_\_\_ Número de Teléfono \_\_\_\_\_

Contacto de Emergencia \_\_\_\_\_ Relación \_\_\_\_\_ Numero de Teléfono de Emergencia \_\_\_\_\_

¿Podemos comunicarnos con usted por teléfono o correo? Sí  No

1. ¿Cuánto le pagan a usted por hora \$ \_\_\_\_\_ ¿Cuántas horas trabaja Ud normalmente por semana? \_\_\_\_\_

2. ¿Cuánto le pagan a su pareja que vive con Ud. por hora? \$ \_\_\_\_\_  
 ¿Cuántas horas trabaja normalmente por semana su pareja que vive con usted? \_\_\_\_\_

3. ¿Usted o su pareja que vive con Ud. reciben propinas? Sí  No  Si reciben, cuánto ganan por semana? \$ \_\_\_\_\_

4. ¿Usted o su pareja que vive con Ud., reciben pago de salario o commission? Sí  No   
 Sí su respuesta es Sí, ¿ Cuánto? \$ \_\_\_\_\_ con cuánta frecuencia? Por semana  Por mes  Por Año

5. ¿Usted o su pareja que vive con Ud. reciben ingresos de, seguro social, discapacidad, desempleo, ayuda familiar, o pensión por divorcio?  
 Sí  No  Sí su respuesta es Sí, Cuánto? \$ \_\_\_\_\_ con cuánta frecuencia? Por semana  Por mes  Por Año

6. ¿Tiene Ud. otro ingreso de la casa? Sí su respuesta es Sí, Cuánto? \$ \_\_\_\_\_ con cuánta frecuencia? Por semana  Por mes  Por Año

**\*\*No ponga zero\*\***  
**\*\*No deje en blanco\*\***

7. Por favor indique el número de personas que viven en su casa, mantenidos con estos ingresos: \_\_\_\_\_

8. Marque la Raza o Razas con la cual se identifica:  
 Blanco  Negro/Afro Americano  Indio Americano /Nativo de Alaska  Asiático  Hawaiano/Pacífico Isleño  Otro  No Reportado/Reusado

9. ¿Ud. se considera Hispano, o Latino? Sí  No

10. ¿Tiene Usted Asegurancia Privada o Medicaid? Asegurancia Privada  Medicaid  No tengo Asegurancia

**Consentimiento**

- Como algunas condiciones médicas pueden afectar mi cuidado, es mi responsabilidad dar un historial médico tan completo y tan exacto como sea posible. Si surgen algunos problemas que tal vez estén relacionados con mi condición, yo entiendo que debo informárselo a la clínica. Entiendo que es mi responsabilidad buscar servicio médico en cualquier otra parte para cualquier otro problema médico más allá de lo que se provee en esta clínica.
- Entiendo que tengo el derecho de negarme a cualquier procedimiento o servicio *incluyendo la prueba rápida del VIH* que se me recomiende. El negarme a recibir cierto tipo de servicio no perjudica que yo pueda recibir servicio apropiado para otros problemas o preocupaciones.
- Sé que todos los servicios proveídos por la clínica son confidenciales. Entiendo que los resultados de algunas pruebas para detectar enfermedades venéreas y otras enfermedades tienen que reportarse al Departamento de Salud en una manera confidencial, según lo requiere la ley.
- Nuestros servicios son confidenciales; sin embargo, si usted tiene menos de 18 años de edad y comparte una historia de abuso sexual o físico, o de negligencia, la ley requiere que lo reportemos al Departamento de Salud y Bienestar (Health and Welfare). Por favor pregúntenos si tiene cualquier pregunta sobre estas leyes.

La persona que firma aquí abajo ha leído, entiende completamente, y está de acuerdo con todas las provisiones e información en este documento.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Official Use Only**

Verified Proof of Income: Pay Stubs  Taxes  Bank Statement  Letter of Benefits

Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_