

NORTHWEST GEORGIA SPECIALTY CARE

CLIENT AGREEMENT POLICY

Specialty Care Mission Statement:

Our mission is to provide quality, compassionate care and support to persons with HIV disease as part of a community-wide response to prevent and combat the impact of the HIV/AIDS epidemic within the ten counties of the NWGA Health District.

Services

- **A positive HIV test result is required** and NWGA Specialty Clinic does not refuse services based on age, religion, race, economic status, sexual orientation or mode of transmission.
- These services are available through the Specialty Clinic:
 - Medical Services
 - Case Management-All clients are assessed and care plans are established
 - Limited Dental Services
 - Nutritional Counseling
 - Mental Health and Substance Abuse Counseling
 - Support Group
 - HIV Risk Reduction and Education
- Provide prevention, counseling and testing to patients' spouses and partners.

CLIENT RIGHTS AND RESPONSIBILITIES

1. Clients have the right to be informed of the services provided by the NWGA Specialty Care Clinic, how to obtain services and reasons for services not provided.
2. Clients have the right to receive considerate, dignified and respectful care and treatment by all clinic personnel.
3. Clients have the right to refuse service or terminate participation without negative consequences.
4. Clients have the right to expect the agency will maintain the confidentiality of all information in charts and records pertaining to the services received, except as otherwise required by law. This does not apply to statistical data, which may be required by funding agencies where the client's identity is not made known.
5. Clients have the responsibility to keep confidential information they may observe or obtain while in the clinic office (such as the identity of other clients or personal information discussed in a group).
6. Clients have the responsibility to notify clinic personnel at least 24 hours in advance if they must cancel an appointment.
7. Clients are responsible for informing clinic staff of any hospital admission or visit to an Emergency Room.

8. English is the primary language of our clinic. If, however, a client does not speak, read, or write English, an interpreter will be provided as well the clinic has access to the AT&T language line.
9. ***Clients are made aware that there is a clinic grievance policy and that it is posted in the clinic area and a copy can be obtained by request at any time.***
10. Clients have a responsibility to follow through on actions agreed upon in his/her individual client service plan.

Appointments

- All services provided by clinic are on appointment basis only.
- Notify the clinic at least 24 hours in advance if you must cancel an appointment.
- Your health is very important to us and we want to partner with you in your healthcare needs. Your role in this partnership is to **keep all scheduled clinical and referral appointments, be on time for appointments** (realize if you come late that we may not be able to give you the full amount of time due to other scheduled appointments) and **failure to bring all your medications** at each appointment may impact the level of care we are able to provide (example: not being able to refill your medications or fill out necessary applications for assistance).

The maximum annual cumulative charges to an individual for HIV-related services are based on the following guidelines:

1. A person whose income falls below 100% of the current federal poverty guidelines is charged no fee.
2. A maximum of 5% of annual income can be charged to persons with income above 100% but less than 200% of the current federal poverty guidelines.
3. A maximum of 7% of annual income can be charged to persons with income between 200% and 400% of current federal poverty guidelines.
4. For persons with income over 400% of current federal poverty guidelines, a limit of 10% of annual income can be charged for services.

Clients are responsible for keeping up with charges and informing the clinic when they have reached their billing percent limit, so they will no longer be charged.

Services will not be denied due to client's inability to pay.

Medication Assistance

- Failure to comply with HAART (Highly Active Anti-Retroviral Treatment) medication plan may result in your body becoming resistant to the drug therapy. This is a serious situation. It is very important for you to take all your HAART medication as directed every day.
- If you would like help with obtaining medicine, you must keep necessary appointments and give all paperwork (like address verification, income information, etc.) asked for by clinic staff. You will be informed by letter and/or verbally the paperwork needed and by what date it is needed. **Failure to provide the paperwork on time may result in**

medication **NOT** being received on time and this may cause a serious health problem.

Involuntary Suspension of Services

When a client engages in behavior that impedes the agency's ability to provide services to that person or others, involuntary suspension may be necessary. A client may be suspended under circumstances where the client does not cooperate with clinic guidelines.

Reasons for suspension include but are not limited to the following:

- Aggressive or abusive behavior toward other clients, volunteers, or staff.
- A medical diagnosis indicating that the client is not HIV positive and that no further medical testing is warranted.
- Repeated failures that would impact the clinician's ability to effectively manage your care may result in dismissal or following through with recommendations discussed with you by the clinician.

Prior to suspension, whenever possible, appropriate staff will meet with the client and establish a written intervention agreement under which the client may continue to receive services.

I have read and received the **Client Agreement Policy (which includes the clients rights and responsibilities)**, the **Clinic's Grievance Policy** and have had my questions answered to my satisfaction. I desire to receive primary and specialty care services through NWGA SPECIALTY CARE CLINIC and those agencies providing services to clinic patients. My signature reflects my commitment to follow my treatment plan, policies of the clinic and adhere to medication regimes prescribed.

I authorize the payment of my health plan benefits to NW GA Specialty Care, supplier of services rendered. I also authorize the release of medical information requested by my health care plan in order to process payment claims.

I have read the above agreement and have had my questions answered to my satisfaction. I agree to abide by these policies and desire clinical and programmatic services through the Northwest Georgia Specialty Care Clinic.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____