Minor Medical Registration Form

First Name: _____ Middle Initial: _____ Last Name: _____

Mailing Address: _____

Street Address (if different from mailing): _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

EMAIL address: _____

DATE OF BIRTH: _____ SEX: _____ SOCIAL SECURITY NUMBER: _____

RESPONSIBLE PARTY (if not you): _____ Their Birthday: _____

RESPONSIBLE PARTIES ADDRESS AND PHONE: _____

EMERGENCY CONTACT: _____ PHONE(S): _____

Relationship to emergency contact (Circle One Please): Spouse Son/Daughter Parent Friend Other (please specify): _____

MARITAL STATUS (Circle One Please): Married Single Divorced Widow/Widower Separated Significant Other

If not English, what is your preferred language: _____

RACE: _____ ETHNICITY: _____

EMPLOYER/ADDRESS: _____

What pharmacy do you use: _____

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. THEY ARE KEPT CONFIDENTIAL AND USED FOR MANDATORY GRANT REPORTING:

Are you a: _____ Veteran _____ Seasonal Worker _____ Migrant Worker _____ Homeless

How many people are in your home, including you: _____ Do you live in public housing: ___ Yes ___ No

What is your TOTAL household income either: _____Annual _____Monthly _____Bi-Weekly _____Weekly

Include child support, disability, social security, welfare, pension, etc. for each family member.

_____Initial here if you are above 201 percent of the posted sliding scale, not eligible for sliding fee discounts & DO NOT want to disclose your income.

TELEHEALTH
(PHONE OR VIDEO)

1. I understand if I engage in a telehealth visit with my health care provider that the phone or video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
2. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
3. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained.
4. If I am doing an in clinic tele-med consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
5. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented. If this is a home conference, there will only be a practitioner fee.
6. I or my insurance may be billed for telehealth services. I am responsible to the Clover Fork Clinic for charges resulting from the services rendered using video or phone conferencing technology at their prevailing rates.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risk and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Signature Date

For Office Use: ACCOUNT NUMBER: _____

GENERAL CONSENT TO TREAT A MINOR:

_____ I am the parent/guardian of _____.

Initial here I have the legal right to consent to medical and surgical treatment for this patient. I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that Clover Fork Clinic (CFC) believe are necessary for this child. I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants, and other health care providers in this medical office to provide treatment to this child as long as this child is a patient in this office, or until I withdraw my consent. I am aware that the practice of medicine is not an exact science and that no guarantee can be made concerning the results of treatment. The minor named in this consent form may receive all medical care provided according to generally and currently accepted standards of pediatric medical care

In the absence of the legal guardian the following people are authorized to bring this minor for medical treatment and have access to his/her medical information. You may name relatives, friends, grandparents, stepparent, non-custodian parent, day care provider, foster parent or others:

NAME:_____ RELATIONSHIP: _____

NAME:_____ RELATIONSHIP: _____

NAME:_____ RELATIONSHIP: _____

If no other person is authorized please circle here: NONE

_____ If a minor is brought by any other person not recorded above, CFC will make reasonable

Initial here attempts to contact me for verbal consent to treat.

_____ If the parent/legal guardian or other authorized person as written above cannot be reached in

Initial here emergent situations, I consent to CFC to render medical care as deemed necessary

_____ If the custody or guardianship of this minor has changed, I will furnish CFC with the legal

Initial here forms that are required to be included in the minor's medical record to explain the change in guardianship. This will alleviate any confusion that may occur over who may or may not consent to minor's treatment.

_____ I have the right to revoke or change this consent to treatment in writing.

Initial here

CONSENT TO RELEASE AND OBTAIN INFORMATION:

_____
Initial here

In agreement with federal and state law, I agree to allow CFC to deliver the necessary care to this child in order to provide continuity of care and treatment. CFC and/or the patient's provider may obtain from any source and examine and use, or discuss and disclose my medical record and information to treating hospital personnel and agents, other health care providers, medical records auditors, professional committees, care evaluators and governmental agencies. We may make your protected information available electronically through an information exchange service to other health care providers that request your information. Participation in information exchange services also lets us see their information about you. This information can include, but is not limited to: medical history, examinations, diagnoses, treatments, any psychiatric, drug and alcohol abuse or genetic testing information, or HIV or AIDS information. This consent to release and obtain information is valid until revoked. I understand that I may revoke the consent in writing at any time, except with regard to disclosures that have already been made in reliance on such consent.

ELECTRONIC PRESCRIPTIONS (E-PRESCRIBING):

_____
Initial here

I voluntarily authorize CFC to allow E-Prescribing for any and all prescriptions, which allows healthcare providers to electronically transmit prescriptions to the Pharmacy of my choice, review pharmacy benefit information and medication dispense history as long as this child is a patient in this office, or until I withdraw my consent.

PERSONAL INFORMATION:

_____
Initial here

I certify the information supplied for my registration to be current, complete, and accurate to the best of my knowledge. I understand by not supplying CFC with all possible insurance coverage could result in a delay of treatment, referrals, diagnostic testing, and create an account balance that I would be solely responsible for. I also authorize the release of any medical or other information necessary to process the above named minor's insurance claim. I authorize payment of medical/dental benefits to Clover Fork Clinic, or any provider that assist Clover Fork Clinic with my care (i.e. Laboratory, Radiology, etc.).

PHONE AND TEXT COMMUNICATION

_____
Initial here

I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to Clover Fork Clinic or updated at a later time, text messages and/or telephone calls or other communications using live and/or prerecorded voices from CFC or anyone who may act on their behalf. Such text messages and/or telephone calls may be related to my account services offered and/or the care rendered. I understand this consent to communications is not required to receive services from CFC or any of the other authorized callers and that data usage and other charges may apply. I may revoke this consent to these communications at any time.

WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF CLOVER FORK CLINIC'S NOTICE OF PRIVACY PRACTICES:

_____
Initial here

I acknowledge receiving CFC's Notice of Privacy Practices (NPP). The Notice explains how CFC may use and disclose your protected health information for treatment, payment and health care operations purpose. "Protected health information" means the personal health information of this minor child, found in his/her medical and billing records.

_____
Initial here

I have read this form or this form has been read to me in a language that I understand and I have had an opportunity to ask questions about it.

IF YOU HAVE QUESTIONS ABOUT THE NOTICE, PLEASE CONTRACT CFC'S PRIVACY OFFICER. CONTACT INFORMATION IS LOCATED IN THE NOTICE.

PLEASE PRINT YOUR NAME: _____

SIGNATURE OF PATIENT: _____ DATE:_____

WITNESSED BY CFC STAFF: _____ DATE:_____
PATIENT ACCOUNT NUMBER: _____

WELCOME TO CLOVER FORK CLINIC

Clover Fork Clinic is a patient-centered, family-focused medical practice dedicated to the health and wellness of the patients and communities we serve.

OUR LOCATIONS

****Walk-ins Accepted****

Clover Fork Clinic of Evarts, KY
101 Chad Street – P.O. Box 39
Evarts, KY 40828
Phone: (606) 837-2108
Fax: (606) 837-2111
Hours
M-F: 8:00 am – 4:30 pm

Pharmacy – Evarts
M, W, T, F: 9:00 am – 5:30 pm
Tues. 10:00 am – 5:30 pm

Clover Fork Clinic of Harlan, KY
209 East Mound Street
Harlan, KY 40831
Phone: (606) 573-1975
Fax: (606) 837-2111
Hours
MONDAY: 8:30 am – 7:00 pm
TUE-F: 8:30 – 5:00 PM

Dental - Evarts
M-F 8:00am – 4:30 pm

FREE PHARMACY DELIVERY

Be Prepared for your Visit

✓Current Insurance Card ✓Photo ID ✓Bring ALL of the medications you are currently taking
✓*Payment – We accept cash, check, and credit/debit* ✓Up-to-date blood pressure or glucose readings
✓Verify your name, address, phone number(s), Insurance carrier(s) and preferred pharmacy
✓Any changes such as marital status, employer, or authorized and/or emergency contacts

****Financial assistance available, sliding fee based on income/household (see attached financial policy)****

Payment arrangements available

AFTER HOURS: Clover Fork Clinic's afterhours nurse line provides access to the clinics Registered Nurse 24 hours, 7 days a week. The nurse can be contacted after hours at (606) 505-5179.

WEB ACCESS: The Clover Fork Clinic will make web access available to all patients. Our electronic communication portal allows patients to access and manage their medical record, request appointments, address billing issues, order refills, and communicate securely with their provider. Please see our receptionist to sign up.

TELEHEALTH: Available as needed.

Please see reception if you need a wheelchair or other assistance with a disability.
Qualified sign language interpreters are available upon request.

The Clover Fork Outpatient Medical Project, Inc. complies with applicable Federal Civil Rights Laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Clover Fork Outpatient Medical Project, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CLOVER FORK CLINIC

Serving families across Appalachia since 1970

Financial Policy

We are committed to providing you with the best possible medical care. If you have special needs; we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning your payment for professions services.

1. Our office accepts most insurance plans (Medicare, Medicaid. And commercial insurance). It is your responsibility to:
    a. Bring your insurance card at every visit.
    b. Be prepared to pay your copayment or minimal fee. Payment can be made by cash, check, or credit card.
    c. You will be billed for medical care not covered under your insurance company.
2. If you have insurance in which we do not participate, our office is happy to file the claim upon request; however, you are expected to pay the minimal payment.
3. If you are UNABLE TO PAY for necessary medical care, you may be eligible for financial assistance and receive a discount based on your household income. Our clinic provides discounts based on a sliding fee scale to individuals who do not have any insurance coverage. It is the patient's responsibility to bring all required documentation before we can process a sliding fee application. Proper proof of income is the most current tax return, the two most recent pay stubs, most recent statement from social services, or a letter from the caregiver with explicit amounts of money that are given on a monthly basis. Sliding scale discounts will be based on the most recent Federal Poverty Index (FPI) guidelines. Patients lacking proper proof of income at the time of their visit must provide this documentation within two weeks. The parent, guardian of a minor is responsible for the minimal payment, if any, at the time of service.
4. If you have questions about your insurance or would like to set up a payment plan, we are happy to help.

HIPAA NOTICE OF PRIVACY PRACTICES
CLOVER FORK OUTPATIENT MEDICAL PROJECT, INC.

THIS NOTICE DESCRIBES HOW MEDICAL INFORAMTION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

This notice describes out privacy practices. All these entities, sites, and locations follow the terms of this notice. I addition these entities, sites and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

Our Pledge Regarding Health information Privacy

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 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 on you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private:
- Give you 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.

How We May Use and Disclose Health Information About You

The following categories describe different ways that we may 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 us 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 that are involved in taking care of you. They may work at our office, at the hospitalized, or at another doctor's office, lab, pharmacy, or other health care provider to whom we may refer you for consultation 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 doctors may need to tell the dietitian at the hospital if you have diabetes so that they can arrange for the 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 file 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 your health information 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 other and to see where we can make improvements. We may remove information that identifies you from this set of health information so that others may use it to study health care delivery without learning who our specific patients are.

To A Business Associate: Certain services are provided to us by third party administrators known as "business associates." For example, we may input information about your health care treatment into an electronic claims processing system maintained by CFOMP's business associate so your claim may be paid. We may disclose your health information to its business associate so they can perform its claims payment function. However, we will require its business associates, through contract, to appropriately safeguard your health information.

Treatment Alternatives: We may disclose your health information to tell you about possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose your health information to tell you about health-related benefits or services that may be of interest to you.

Individual Involved in Your Care or Payment of Your Care: We may disclose health information to a close friend or family member involved in or who helps pay for your health care. We may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death.

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

Special Use and Disclosure Situations

We may also use or disclose your health information under the following circumstances:

Lawsuits and Disputes: If you become involved in a lawsuit or other legal action, we may disclose your health information in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process by someone else involved in dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

- In response to a valid court order, subpoena, warrant, summons or similar process:
- In reporting certain injuries, as required by law, gunshot wounds, burns, injuries to perpetrators of crime.
- To identify or locate a suspect, fugitive, material witness or missing person

Worker's Compensation: We may disclose your health information for worker's compensation or similar programs. These programs provide benefit for work-related injuries or illness.

Military and Veterans: If you are or become a member of the U.S. armed forces, we may release health information about you as requires 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.

To Avert Serious Threat to Health or Safety: We may use and disclose your health information when necessary to prevent 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.

Public Health Risks: We may disclose health information about you for public health activities. These activities generally include the following:

1. To prevent or control disease, injury, or disability.
2. To report births and deaths.
3. To report child abuse or neglect.
4. To report reactions to medication or problem with products.
5. To notify people of recalls of products they may be using.
6. 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
7. To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will make this disclosure if you agree or when required by law.

Health Oversight Activities: We may disclose your health information to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs. All or a portion of your health information may also be released to the Kentucky Health Information Exchange (KHIE), Kentucky Cancer Registry, Immunization Registry, and your school if applicable. An individual has a right to adequate notice of the uses and disclosures of health information that may be made by the cover entity (45 C.F.R. 164.520 (a) (1)).

Research: Upon patient authorization, we may use and disclose your health information for medical research purposes.

National Security, Intelligence Activities, and Protective Services: We may release your health information to authorized federal officials:

1. For intelligence, counterintelligence, and other national security activities authorized by law and
2. To enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Coroners, Medical Examiners, and Funeral Directors: We may release your health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We may also release your health information to a funeral director, as necessary, to carry out his/her duty.

Clover Fork Outpatient Medical Project, Inc offers patient support of reproductive health care privacy with attestation forms when requested use or disclosure of protected health information potentially related to reproductive health care is needed.

Your Rights Regarding Health Information About You

Your rights regarding the health information we maintains about you are as follows:

Right to Inspect and Copy: You have the right to inspect and copy your health information. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes.

To inspect and copy health information maintained by we, submit your request to in writing to we Administrator. We may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, we may deny your request to inspect and copy your health information. Generally, if you are denied access to health information, you may request a review of the denial.

Right to Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask we to amend it. You have the right to request an amendment for as long as the information is by or for we.

To request an amendment, send detailed request in writing to our Administrator. You must provide the reason(s) to support your request. We may deny your request if you us to amend health information that was: accurate and complete, not created by us; not part of the health information kept by or for us; or not information that you would be permitted to inspect and copy.

Right to An Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of disclosures of your health information that we have made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; or in certain other situations.

To request an accounting of disclosures, submit your request in writing to our Administrator. Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested and may not include dates before April 14, 2003.

Right to Request Restrictions: You have the right to request a restriction on the health information we uses or disclosures about you for treatment, payment, or healthcare 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, like a family member of friend. For example, you could ask that we not use or disclose information about a surgery you had.

To request restrictions, make your request in writing to our Administrator. **You must advise us:**

1. What information you want to limit;
2. Whether you want to limit our use, disclosure, or both; and
3. To whom you want the limit(s) to apply.
4. *Note: We are not required to agree to your request.*

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 send your explanation of benefits (EOB) forms about your benefit claims to a specified address. To request confidential communications, make your request in writing to our Administrator. We will make every attempt to 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 a paper copy of this notice. You may write our Administrator to request a written copy of this notice at any time.

Changes to this Notice: We reserve the right to change this notice at any time and to make the revised or changed notice effective for health information we already has about you, as well as any information we receives in the future. We will post a copy of the current notice in the Administrative Office, patient lobby at all times and on the website. CFOMP participants will be notified 60 days of a material revision.

Complaints: If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Administrator at the address listed below. Alternatively, you may complain to the Secretary of the U.S. Department of Health and Human Services, generally, within 180 days of when the act or omission complained of occurred.

Note: You will not be penalized or retaliated against for filing a complaint.

Other Uses and Disclosures of Health Information:

Other uses and disclosures of health information not covered by this notice or by the laws that apply to we will be made only with your written authorization, we will no longer use or disclosure your health information, and you may revoke the authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclosure your health information for the reasons covered by your written authorization; however, we will not reverse any uses or disclosures already made in reliance on your prior authorization.

Contact Information

If you have any questions about this notice, please contact:

Clover Fork Outpatient Medical Project, Inc.
101 Chad St.
Evarts, KY 40828
(606) 837-2108

WHAT YOU SHOULD KNOW ABOUT HIV & AIDS^

WHAT IS HIV?

Human Immunodeficiency Virus (HIV) is a virus that weakens your immune system by destroying specific cells that fight infection and disease. HIV is an infection that progresses in three stages:

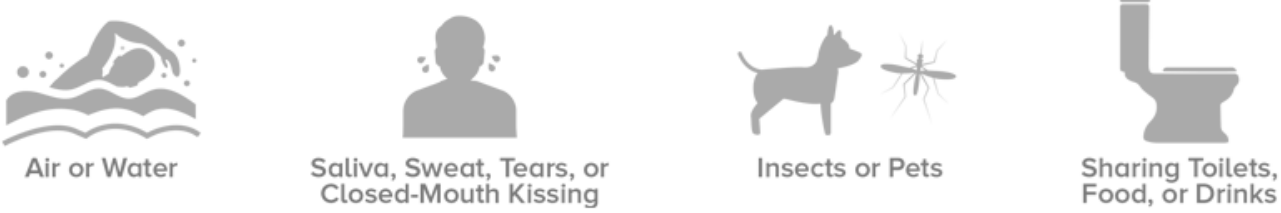
STAGE 1	Acute HIV infection	A person with acute HIV may develop flu-like symptoms within 2-4 weeks of infection, with symptoms that may last for several weeks.
STAGE 2	Chronic HIV infection	Once a person's body is infected, it is infected for life. However, with proper medical care, a person with HIV may live nearly as long as someone who does not have HIV. Untreated HIV can progress to AIDS, typically 8-10 years after testing positive for HIV.
STAGE 3	AIDS	**Acquired Immunodeficiency Syndrome (AIDS)** is the most severe phase of HIV infection. AIDS is diagnosed when the CD4 T cell count falls below 200, or a person experiences an AIDS-defining complication (e.g., serious infection or cancer). Antiretroviral therapy (ART) can prevent HIV from destroying the immune system and advancing to AIDS. Without treatment, people with AIDS can survive about 3 years.

WHAT IS AIDS?

HOW IS HIV TRANSMITTED?

- Sexual contact (oral, anal, or vaginal intercourse) with an infected person when blood, pre-ejaculation fluid, semen, cervical/vaginal, and/or anal mucus secretions are exchanged
- Sharing syringes, needles, cotton, cookers, and other drug injecting equipment with someone who is infected
- Receiving contaminated blood or blood products (very unlikely after March 1985)
- An infected mother, not on ART, can pass HIV to her unborn child before or during childbirth, or through breastfeeding
- Receipt of transplant, tissue/organs, or artificial insemination from an infected donor (very rare)
- Needle stick or other sharps injury in a health care setting involving an infected person (very rare)

HIV IS NOT TRANSMITTED BY



EARLY DIAGNOSIS OF HIV INFECTION IS IMPORTANT!

GETTING TESTED FOR HIV:

Everyone should be tested at least once for HIV.
The Centers for Disease Control and Prevention (CDC) recommends persons who report any of the activities listed below should be tested at least yearly:

- A man who has had sex with another man*
- Injecting not medically prescribed drugs and sharing needles or other drug equipment
- Exchanging sex for money or drugs
- Diagnosed with or treated for another sexually transmitted infection, hepatitis, or tuberculosis
- Having more than one sexual partner since their last HIV test
- Having unprotected sex or sex with someone who has had unprotected sex

* Sexually active men who have sex with men may benefit from more frequent testing (e.g., every 3–6 months)

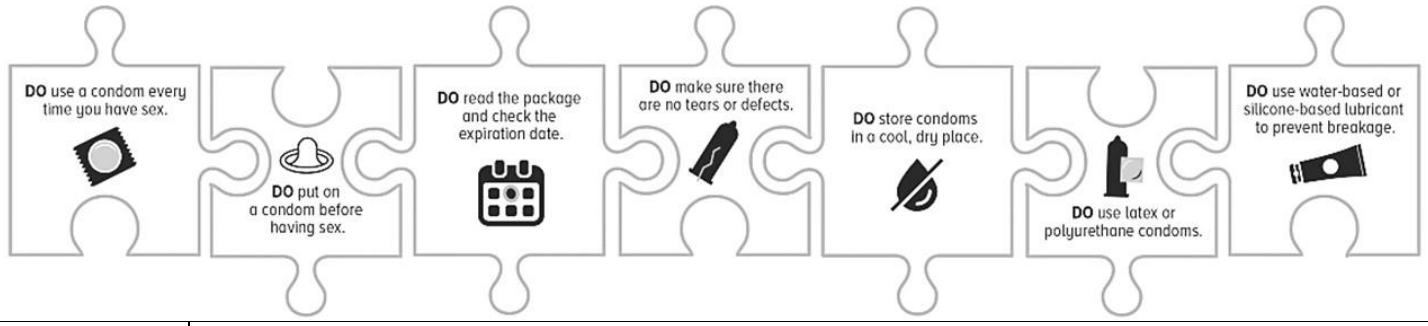
New infections may be identified as early as 4 weeks with new advances in screening tests. Free anonymous and confidential testing and counseling is available at every health department in Kentucky. If you have HIV, seek care immediately and a provider will help determine the best treatment plan. In many cases, early treatment can enhance a person's ability to remain healthy as long as possible.

Remember, you cannot tell whether someone has HIV just by looking at them!

HOW CAN I PREVENT HIV?

- Educate yourself and others about HIV infection and AIDS
- Do not share needles or other drug paraphernalia
- Practice "safer" sex:
  - ✓ Abstinence (not having sex of any kind)
  - ✓ Sex only with a person who does not have HIV, does not practice unsafe sex, or inject drugs
  - ✓ Using either a male or female condom or dental dam (for oral sex)
  - ✓ Do not share sex toys
- Persons at higher risk can help prevent HIV infections through the use of pre-exposure prophylaxis (PrEP)
- Exercise universal precautions when coming into contact with HIV infected blood, semen, or vaginal fluid

HOW TO CORRECTLY USE A MALE CONDOM:



WHAT IS PrEP?

PrEP means taking HIV medication (i.e., Truvada, Descovy, Apretude) by persons who have not been diagnosed with HIV, but who are at risk of acquiring HIV via sex or injection drug use. When taken as prescribed, PrEP can effectively stop HIV infection. Persons taking PrEP should continue to use condoms for maximum protection.

WHAT IS PEP?

Post-exposure prophylaxis (PEP) is an HIV medication taken within 72 hours (3 days) of a potential exposure to HIV. PEP is intended for persons who have tested negative for HIV or are uncertain of their HIV status and should only be used in emergency situations.

WOMEN AND HIV/AIDS

All pregnant women should have blood tests to check for HIV infection.

Women diagnosed with HIV who are not on treatment can pass HIV infection to their babies during pregnancy, labor and delivery, and through breastfeeding. Risk of passing HIV to the baby is 1% or less if they practice all of the following:

- Take ART daily
- Give HIV treatment to her baby for 4-6 weeks after giving birth
- Do not breastfeed or pre-chew her baby's food

UNDETECTABLE = UNTRANSMISSIBLE

Persons with HIV who take their HIV medicine as prescribed may remain virally suppressed or undetectable and healthy, with effectively no risk of sexually transmitting HIV to their HIV-negative partners.

LIVING HEALTHY WITH HIV

Begin treatment as soon as possible and take prescribed medications daily. Maintaining an undetectable viral load is the key to living a longer, healthier life.

- Healthy living behaviors for the general public are even more important for those living with HIV:
  - ✓ A healthy diet provides energy and nutrients a person's body needs to fight disease and infections (It may also improve absorption of prescribed medications and may help offset potential side effects.)
  - ✓ Exercise strengthens the immune system to better combat infections
- Discordant couples are at higher risk of HIV transmission:

HIV Negative Partner Should:	○ Be routinely tested for HIV ○ Ask their health care provider about PrEP
HIV Positive Partner Should:	○ Take ART daily as prescribed
Both Partners Should:	○ Use condoms during sex ○ Not engage in sex with other people

THIS AGENCY PROVIDES QUALITY SERVICES TO ALL PATIENTS, REGARDLESS OF HIV STATUS.

IF YOU NEED MORE INFORMATION CALL:

1-800-CDC-INFO (232-4636) | 1-888-232-6348 TTY

Kentucky HIV/AIDS Program 502-564-6539

-or-

Your local health department's HIV/AIDS Coordinator

^retrieved 6/17/2020 from: https://www.cdc.gov/hiv/basics/