DENTAL REGISTRATION FORM

NAME: First: _____ Middle: _____ Last: _____

Mailing Address: _____

Street Address (If Different from Mailing): _____

Phones: Home: _____ Cell: _____ Work: _____

Which phone do you prefer we use to contact you? Home: ____ Cell ____ Work _____.

Do you prefer to be called in the AM ____ Afternoon ____ Evening____?

What is your Email address: _____

(By providing you will be sent an email to join our patient portal.)

Date of Birth: _____ Sex: _____ Social Security Number _____

Responsible Party (If not you): _____Their Birthday: _____ Relationship: _____

Responsible Parties Address & Phone: _____

Emergency Contact: _____Phone: _____

Relationship to emergency contact: Spouse ___ Son/Daughter ___ Parent ___ Friend ___ Other ___ Please Specify _____

Marital Status: Married ___ Single ___ Divorced ___ Widow/Widower ___ Separated ___ Significant Other ___

If married, name of spouse: _____ Closest Relative: _____ Phone ( ) _____

If not ENGLISH, what is your preferred language: _____

Race: _____ Ethnicity: _____

Employer Address: _____

What pharmacy do you use? _____

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

Do you have city water at your home: yes ___ no ___ Do you live in public housing: yes ___ no ___

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

How many people are in your home, including you? _____

What is your TOTAL household income, either: Annual _____ Monthly _____ Bi-weekly _____ Weekly _____

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

_____ Initial here if you are above 201 percent of the posted sliding scale, not eligible for sliding fee discounts & <u>DO NOT</u> want to disclose your income.

Chief Dental Complaint _____

_____

1. Do you/your child have any pain in your jaws or face? ..... Yes No
2. Do you/your child have a toothache? ..... Yes No
3. Are you receiving any topical fluoride application? ..... Yes No
4. Have you had any serious trouble with any previous dental treatment? ..... Yes No
5. Have you ever been told to take premedication prior to a dental visit? ..... Yes No
6. Do you have dry mouth? ..... Yes No
7. Do you have halitosis (bad breath)? ..... Yes No
8. Do you use any prescription dental products? ..... Yes No
9. Are you using any whitening products? ..... Yes No
10. Do you use a sonic or power toothbrush? ..... Yes No
11. Do you have sensitive teeth? ..... Yes No
12. Do you wear any dental appliances? ..... Yes No
    If so, what appliance and where? _____
13. How often do you brush? _____
14. How often do you floss? _____
15. When was your last dental visit? _____
16. What was your last dental visit for? _____
17. When was the last time you had your teeth cleaned? _____
18. When was the last time you had dental x-rays? _____

1. Name of physician? _____ Yes No
2. Have you been hospitalized in the past 5 years? ..... Yes No
3. Are you taking any medications? .....
   If so, please list medicines _____
4. Do you have any of the following:
   a. Cardiovascular disease (heart trouble, heart attack, angina, high blood pressure, stroke, stints, or Yes No
      cardiac pacemaker)? ..... Yes No
   b. Are you taking any blood thinners including aspirin? ..... Yes No
   c. Do you take nitroglycerin? ..... Yes No
      If so, do you carry it with you? ..... Yes No
   d. Heart murmur, rheumatic heart disease, damaged or artificial heart valves? .....
   e. Seasonal allergies Sinus Trouble Asthma (Circle Those that Apply) Yes No
   f. Fainting spells or seizures? ..... Yes No
   g. Epilepsy? ..... Yes No
   h. Diabetes? ..... Yes No
   i. Hepatitis? What type? _____ ..... Yes No
   j. AIDS or HIV infection? ..... Yes No
   k. Thyroid problems? ..... Yes No
   l. Respiratory problems? ..... Yes No
   m. Arthritis? What type? _____ ..... Yes No
      Are you taking bisphosphonates such as: Fosamax, Boniva, Actonel, or Reclast or other? ..... Yes No
   n. Stomach problems? ..... Yes No
   o. Kidney problems? ..... Yes No
   p. Tuberculosis? ..... Yes No
   q. Problems with mental health: (If yes circle one below) .....
      Anxiety Depression ADHD or ADD Schizophrenia Autism Other _____ Yes No
   r. Cancer? ..... Yes No
      Are you taking Chemotherapy? ..... Yes No
      Are you taking radiation? ..... Yes No
   s. Do you have problems with your immune system? ..... Yes No
      Lupus? ..... Yes No
   t. Have you had any artificial hip or knee replacements? ..... Yes No
   u. Have you ever had endocarditis? ..... Yes No
   v. Abnormal bleeding? ..... Yes No
      Anemia? .....
5. Are you allergic to or have you had a reaction to: Yes No
   a. Local anesthetics? ..... Yes No
   b. Penicillin or other antibiotics? ..... Yes No
   c. Sulfa drugs? ..... Yes No
   d. Codeine or other narcotics? ..... Yes No
   e. Latex? ..... Yes No
   f. Other? _____ ..... Yes No
6. Have you had any condition or problem not listed above that you think I should know about? ..... Yes No
7. Taking birth control pills? ..... Yes No
8. Are you pregnant? ..... Yes No
9. Are you nursing? ..... Yes No
10. Do you have a history of alcohol or substance abuse? ..... Yes No
    If yes, please list _____
11. If you use nicotine, what form do you use? _____

WELCOME TO CLOVER FORK CLINIC

Clover Fork Clinic is a patient-centered, family-focused, federally qualified health center look-alike 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 Front Desk Closes

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
Tuesday – Friday 8:30 am – 5:00 pm

Pharmacy - Evarts
M, W, T, F: 9:00 am – 5:30 pm
Tues. 10:00 am – 5:30 pm
Dental - Evarts
M-F: 8:00 am – 4:30 pm

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

****See our Financial Policy on the back side of this letter. It also contains our sliding fee discounts.****

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.

Please see reception if you need a wheelchair or other assistance with a disability.

Qualified language and sign language interpreters are available upon request .

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 and family size. 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.

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

GENERAL CONSENT TO TREAT:

_____ Initial Here

I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that Clover Fork Clinic (CFC) believes are necessary. 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 as long as I am 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. I may receive all medical care provided according to generally and currently accepted standards of medical care.

_____ Initial Here

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

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 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.

IN ABSENCE OF THE PATIENT: the following people are authorized to have access to his/her medical information. (You may name a spouse, children, or other relatives, friends, adult care providers or others).

Name: _____ Relationships: _____

Name: _____ Relationships: _____

If no other person, besides the patient is authorized please circle: NONE

ELECTRONIC PRESCRIPTIONS (E-PRESCRIBING):

_____ Initial Here

I voluntarily authorize CFC to allow E-Prescribing for any and all prescription, 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 I am 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 my insurance claim. I authorize payment of medical/dental benefits to Clover Fork Clinic.

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 your personal health information found in your 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.

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

PLEASE PRINT YOUR NAME: _____

SIGNATURE OF PATIENT: _____ DATE: _____

WITNESSED BY CFC STAFF: _____ DATE: _____

TELEHEALTH
(PHONE OR VIDEO)

1. I understand if I engage in a telehealth visit with my health care provider that the 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 telemed 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

WHAT YOU SHOULD KNOW ABOUT HIV & AIDS

WHAT IS AIDS?

AIDS is the Acquired Immune Deficiency Syndrome – a serious illness that makes the body unable to fight infection. A person with AIDS is susceptible to certain infections and cancers. When a person with AIDS cannot fight off infections, this person becomes ill. These infections can eventually kill a person with AIDS.

WHAT CAUSES AIDS?

The human immunodeficiency virus (HIV) causes AIDS. Early diagnosis of HIV infection is important! If you have been told that you have HIV, you should get prompt medical treatment. In many cases, early treatment can enhance a person's ability to remain healthy as long as possible. Your doctor will help you determine the best treatment for you. Free or reduced cost anonymous and confidential testing with counseling is available at most local health departments in Kentucky. After being infected with HIV, it takes between two weeks to six months before the test can detect antibodies to the virus.

HOW IS THE HIV VIRUS SPREAD?

- Sexual contact (oral, anal, or vaginal intercourse) with an infected person when blood, pre-ejaculation fluid, semen or cervical/vaginal 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 now because blood used in transfusions has been tested for HIV antibodies since March 1985).
- An infected mother passing HIV to her unborn child before or during childbirth, and through breast feeding.
- Receipt of transplant, tissue/organs, or artificial insemination from an infected donor.
- Needle stick or other sharps injury in a health care setting involving an infected person. Infections can sometimes be prevented by taking post-exposure prophylaxis anti-retroviral drugs. Strict adherence to universal precautions is the best way to prevent exposures.

YOU CANNOT GET HIV THROUGH CASUAL CONTACT SUCH AS:

- Sharing food, utensils, or plates
- Touching someone who is infected with HIV
- Hugging or shaking hands
- Donating blood or plasma (this has NEVER been a risk for contracting HIV)
- Using public rest rooms
- Being bitten by mosquitoes or other insects
- Using tanning beds (always clean before and after use)

HOW CAN I PREVENT HIV/AIDS?

- Do not share needles or other drug paraphernalia.
- Do not have sexual intercourse except with a monogamous partner whom you know is not infected and who is not sharing needles. If you choose to have sex with anyone else, use latex condoms (rubbers), female condoms or dental dams, and water based lubricants every time you have sex.
- Educate yourself and others about HIV infection and AIDS.

WOMEN AND HIV/AIDS

For females with HIV/AIDS in Kentucky, heterosexual exposure and injection drug use are the most common modes of transmission of HIV. HIV can be spread through body fluids (i.e., blood, semen, vaginal secretions, and breast milk).

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

- Mothers can pass HIV infection to their babies during pregnancy, labor and delivery, and by the child ingesting infected breast milk.
- Without treatment, about 25% (1 out of 4) of the babies born to HIV infected women will get HIV.
- Medical treatment for the HIV infected woman during pregnancy, labor, and delivery can reduce the chance of the baby getting HIV from its mother to less than 2% (less than 2 out of 100).
- An HIV infected mother should not breastfeed her newborn baby.

IS TREATMENT AVAILABLE IF I ALREADY HAVE HIV/AIDS?

After being infected with HIV, it takes between two weeks to six months before the test can detect the HIV virus. **Early diagnosis of HIV infection is important!** Free anonymous and confidential testing and counseling is available at every Health Department in Kentucky. Testing requires drawing a small tube of blood from a vein in your arm. If you have HIV, you should get prompt medical treatment. In many cases, early treatment can enhance a person's ability to remain healthy as long as possible. Your doctor will help you determine the best treatment.

GETTING TESTED FOR HIV:

If you have never been tested for HIV, you should be tested at least once. Centers for Disease Control and Prevention (CDC) recommends being **tested at least once a year if you do things that can transmit HIV.** These include:

- Injecting drugs or steroids with used injection equipment
- Having sex with someone who has HIV or any sexually transmitted disease (STD)
- Having more than one sex partner since your last HIV test
- Having a sex partner who has had other sex partners since your last HIV test
- Having sex for money or drugs (prostitution- male or female)
- Having unprotected sex or sex with someone who has had unprotected sex
- Having sex with injecting drug user(s)
- Having had a blood transfusion between 1978 and 1985
- Pregnant women or women desiring to become pregnant

WHAT IS UNSAFE SEX?

- Vaginal, anal, or oral sex without using a condom or dental dam

Remember: You can't tell whether or not someone has HIV just by looking at them!

- Sharing sex toys
- Contact with HIV infected blood, semen, or vaginal fluid

WHAT IS "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)

How to use a latex condom:

1. Use a new latex condom every time you have sex.
2. The condom should be rolled onto the erect (hard) penis, pinching ½ inch at the tip of the condom to hold the ejaculation (semen) fluid. Air bubbles should be smoothed out.
3. Use plenty of WATER-BASED lubricants such as K-Y Jelly, including a drop or two inside the condom, before and during intercourse. **DO NOT USE** oil-based lubricants such as petroleum jelly, mineral oil, vegetable oil, Crisco, or cold cream.
4. After ejaculating, withdraw the penis holding the condom at the base so it will not slip off.
5. Throw away the used condom into a garbage can and wash hands.

IF YOU NEED MORE INFORMATION CALL:

Kentucky HIV/AIDS Program 502-564-6539

The National AIDS Hotline 1-800-342-AIDS

This agency provides quality services to all patients, regardless of HIV status.

Your local health department's HIV/AIDS Coordinator

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