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Appointment:
Date: ____/____/_____ Time: _____:_____ AM/PM
Date has to be completed by: ____/____/_____

GoalConnect
Setting Goals, Connecting Resources

Laramie County Common Intake Form for the Sliding Fee Scale

What you need to provide to apply: Must submit all documents within 10 working days of application.

- **Photo Identification:** Examples are Driver's License, State ID, Passport, or Student Photo ID
- **Private Insurance Coverage Card, Medicare Part B Card, Medicare Part D Card, or Medicaid Card**
- **Student:** Copy of current financial aid statement or most recent tuition statement (1098-T) from the institution you are attending
- **Proof of Residency**
  - Examples – Utility or medical bill with name and address, rent receipt with name and address, proof of staying in a group home shelter or residential treatment facility
- **For Sliding Fee Application**
  - To determine where you fall on the sliding fee scale, we must first determine household income.
    - A household is defined as:
      - All individuals listed on your tax return,
      - A tax return where you are listed as a spouse or dependent,
      - Or anyone whom the patient or guardian is legally obligated to care for.
    - To document household income, the following documentation is required:
      - **Most Recent Tax Return** (which has been signed and filed within the last 12 months)
      - If you are unable to provide a copy of the tax return, please contact the IRS office at (844)545-5640 to schedule an appointment at 5353 Yellowstone Road (2nd floor) or visit their website at irs.gov, to request a **verification of non-filing** for the most recent tax season.
      - If your current income is **not** reflected on your tax return, please provide income documentation for the last 90 days.
        - Current paystubs, a completed Employer Statement Form, current social security benefit letter, unemployment benefit/denial letter, Veterans' benefits, Alimony, Child Support, retirement benefits, or worker's compensation statement.
      - If you have NO INCOME, **in addition** to your tax return or verification of non-filing from the IRS, please also include:
        - A copy of the denied unemployment letter/copy of employment history from the Department of Workforce Services.
        - A printout of the **Benefit History** from the Department of Family Services that shows eligibility for the Wyoming SNAP program.
        - A letter verifying a recent stay at a shelter, or other type of public facility.
        - A written statement from your physician documenting temporary disability.
        - If none of the above is available, please complete a statement of self-declared income.

PLEASE NOTE: Each participating agency has agreed to use a consistent data collection form but each agency may have different eligibility rules or service fees.

UNIVERSITY OF WYOMING

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APPLICANT INFORMATION

What language do you speak? ☐ English ☐ Spanish ☐Other _____ What language do you write? ☐English ☐ Spanish ☐Other _____ Did someone complete this form on your behalf? ☐Yes ☐No SI NECECITA ESTA FORMA EN ESPAÑOL POR FAVOR AVISENOS.	**Today's Date:** **Social Security #**	**Agency Use Only:** ☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G ☐100% Self Pay Annual Income $_____._____ Household size_____ Eligible from _____thru_____

Legal Last Name	First Name, Middle Initial	Birth Date	Gender M F	Other/Former/Maiden Name(s)
Physical Address	City	State	Zip Code	County
Mailing Address/P.O. Box	City	State	Zip Code	County
Home Phone	Message Phone	Are you a U.S. Citizen? ☐Yes ☐No		Marital Status (check one) ☐Never Married ☐Married ☐Divorced ☐ Legally Separated ☐Widowed ☐Minor Child
Cell Phone	Work Number	Email Address		

Race (check all that apply) ☐Asian ☐African American ☐American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐Other/Multi Racial ☐ White ☐Decline to answer ☐ Unavailable	Ethnicity (check one) ☐Not-Hispanic ☐Hispanic/Latino ☐ Ethnic Black ☐Decline to answer ☐ Unavailable	Housing Information (check one) ☐Own ☐Rent ☐HUD/CHA ☐Homeless ☐Rent Free ☐Group Home	Are you a Veteran? ☐No ☐Non-Combat ☐Combat

Employment (check one): ☐Full Time ☐Part Time ☐Self Employed ☐Unemployed ☐Student ☐Disabled ☐Retired ☐Seasonal☐ Migrant	Employer Name	Employer Phone Number
	Employer Address	Date Hired

Emergency Contact Name	Emergency Contact Phone Number	Relationship to Patient
If you are unemployed, have you filed for Unemployment? Yes___ No___ If yes, please provide Approval or Denial Letter	If currently working, how long have you worked for the current employer. _____	If you are unemployed, do you intend to go back to work? Yes____No____ If yes, when_____
(For Dependents, Only) Name of Parent/Guardian	Relationship to Patient	Family Size

Recently lost employment? ☐Yes ☐No	Place of Birth (city, county, state)	Client's Mother's first name	Highest Grade Client Completed

May we leave you an appointment reminder message? ☐ Yes ☐ No
If yes, please check all that apply ☐Home ☐Cell ☐Work ☐Message Phone

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INSURANCE INFORMATION

Health Insurance? ☐Yes ☐No	Medicare if yes please include policy # ☐Yes ☐No	Equality Care/Medicaid if yes please include policy # ☐Yes ☐No	Kid Care if yes please include policy # ☐Yes ☐No	Prescription Coverage ☐Yes ☐No
Prescription coverage from Prescription Drug Assistance Program (PDAP)? ☐Yes ☐No		Medicare Part D ☐Yes ☐No	If unemployed, are you eligible for COBRA benefits? ☐Yes ☐No	

Insurance Company		Subscriber ID	Group ID
Policy Holder Name	Birth Date of Policy Holder __/__/__	Relationship to Patient	Policy Holder SSN
Billing Claims Address:	Customer Service Phone: (___) _____-_____	Employer:	Employer phone: (___) ___-_____

Secondary Insurance Company		Subscriber ID	Group ID
Policy Holder Name	Birth Date of Policy Holder __/__/__	Relationship to Patient	Policy Holder SSN
Billing Claims Address:	Customer Service Phone: (___) _____-_____	Employer:	Employer phone: (___) ___-_____

Are you seeking medical care because of an accident? ☐Yes ☐No If yes, answer following questions...

Date of accident: / /	Was it a motor vehicle accident? ☐Yes ☐No	Was the accident work related? ☐Yes ☐No	Where did the accident occur?
Workers Compensation number:	If motor vehicle accident, name of auto insurance company and policy number:		Do you have an attorney involved and/or a settlement pending? ☐Yes ☐No

ASSIGNMENT AND RELEASE: I authorize HealthWorks to disclose medical information as necessary to receive payment and assign all benefits, if any, directly to HealthWorks that otherwise might be payable to me for services rendered. I understand HealthWorks may also release medical information about me to physicians or other health care providers who may be involved in my continued care. I understand that this authorization will remain in effect for twelve (12) months. If I choose to seek medical care with another provider, I understand that the treatment and information may still be shared with my insurance or another medical carrier. I understand that HealthWorks will file an initial claim with Medicare, Medicaid, or any other third party insurance, if I have provided and signed the necessary information and/or forms. I understand that I am financially responsible for all my charges whether they are covered by my insurance carrier. I also agree to be responsible for payment of any services rendered if my insurance company takes longer than sixty (60) days from date of service. If this occurs, I will be responsible for seeking reimbursement from my insurance company. I authorize the use of this signature on all insurance submissions. I understand that if I fail to make a good faith effort to keep my account current HealthWorks reserves the right to refuse non-acute medical services and to engage a collection agency for any outstanding balances.

Signature of Responsible Party: _____ **Print Patient Name:** _____

Relationship to Patient: _____ **Date:** _____

Initials_____ Pt#_____

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SLIDING FEE DISCOUNT APPLICATION

Tell us about each member of your Household:

Please list every household member claimed on your tax return. **(Please use additional pages if needed.)**

Household Member (relationship to applicant)		Insurance Coverage?	Type of Income for Household Member Gross Total Income Per Month (income before taxes and deductions are taken out)			
☐ Self _____ Last _____ First MI	**Gender** ☐M☐F **Birth Date** ____/____/_____ **SSN:** _____-_____-_____ Can anyone claim you as a **dependent** on their tax return? ☐ Yes ☐ No	☐ No ☐ Yes Insurance Name: ☐ Medicare ☐ Medicaid ☐ _____ Please list Medicaid #_____	☐Wages $ _____ ☐Self-Employment $ _____ ☐Worker's Comp $ _____ ☐Unemployment $ _____ ☐Social Security/SSI $ _____ ☐Military/VA Benefits $ _____ ☐Pension/Retirement $ _____ What year was your last tax return filed:_____	☐Trust Fund Monies $ _____ ☐Alimony $ _____ ☐Child Support $ _____ ☐Rental Income $ _____ ☐Investments $ _____ ☐Other ☐No income $ _____ See next section		
☐Spouse ☐Child ☐Step-Child ☐Sibling ☐Parent ☐Step-Parent ☐Other: _____ Last _____ First MI	**Gender** ☐M☐F **Birth Date** ____/____/_____ **SSN:** _____-_____-_____ Is this person is included on your tax return? ☐ Yes ☐ No	☐ No ☐ Yes Insurance Name: ☐ Medicare ☐ Medicaid ☐ _____ Please list Medicaid #_____	☐Wages $ _____ ☐Self-Employment $ _____ ☐Worker's Comp $ _____ ☐Unemployment $ _____ ☐Social Security/SSI $ _____ ☐Military/VA Benefits $ _____ ☐Pension/ Retirement $ _____ What year was your last tax return filed:_____	☐Trust Fund Monies $ _____ ☐Alimony $ _____ ☐Child Support $ _____ ☐Rental Income $ _____ ☐Investments $ _____ ☐Other ☐No income $ _____ See next section		
☐Spouse ☐Child ☐Step-Child ☐Sibling ☐Parent ☐Step-Parent ☐Other: _____ Last _____ First MI	**Gender** ☐M☐F **Birth Date** ____/____/_____ **SSN:** _____-_____-_____ Is this person is included on your tax return? ☐ Yes ☐ No	☐ No ☐ Yes Insurance Name: ☐ Medicare ☐ Medicaid ☐ _____ Please list Medicaid #_____	☐Wages $ _____ ☐Self-Employment $ _____ ☐Worker's Comp $ _____ ☐Unemployment $ _____ ☐Social Security/SSI $ _____ ☐Military/VA Benefits $ _____ ☐Pension/ Retirement $ _____ What year was your last tax return filed:_____	☐Trust Fund Monies $ _____ ☐Alimony $ _____ ☐Child Support $ _____ ☐Rental Income $ _____ ☐Investments $ _____ ☐Other ☐No income $ _____ See next section		

Initials_____ Pt#_____

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SLIDING FEE DISCOUNT APPLICATION (Continued)

IF NO INCOME IS INDICATED

If you have no income, please indicate which of the following you can provide as documentation:

- ☐ A copy of denied unemployment letter/copy of employment history from the Department of Workforce Services,
- ☐ A printout of the "Benefit History" from the Department of Family Services that shows eligibility for the Wyoming SNAP program,
- ☐ A letter verifying a recent stay at a shelter, or other type of public facility.
- ☐ A written statement from your physician documenting temporary disability
- ☐ Statement of Self-Declared Income

Can we provide information about payment arrangements for you?	☐Yes	☐No
Have you recently lost employment? Are you eligible for COBRA benefits? Please list employer _____	☐Yes ☐Yes	☐No ☐No
Are you unable to obtain insurance due to a pre-existing condition?	☐Yes	☐No
Have you ever filed for bankruptcy or do you intend to? If yes, what State? _____ Case #? _____File date? _____ Discharge date? _____ Is the reason for the filing due to medical bills?	☐Yes ☐Yes	☐No ☐No
Would you like us to share your sliding fees scale eligibility with any of the following partners? Please indicate which agencies ☐ HealthWorks Clinic ☐ University of Wyoming Residency Program ☐ HealthWorks Pharmacy ☐ Cheyenne Regional Medical Center ☐ Cheyenne Physicians Group ☐ Peak Wellness Center	☐Yes	☐No

My signature indicates that all the information I have provided is true and correct. I hereby grant permission to this agency to obtain and share the information I have provided for determining eligibility for assistance. I understand that failure to disclose insurance coverage for services provided or any household income will exclude me from receiving discounts and the agencies in which I applied for discounts have the right to full legal recourse to collect full billed charges.

Signature of Responsible Party: _____ **Print Patient Name:** _____

Relationship to Patient: _____ **Date:** _____

Agency Representative: _____ **Date:** _____

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Cheyenne Health and Wellness Center (CHWC)

(DBA: HealthWorks, and Prescription Assistance Program (PAP)

CONSENT FOR TREATMENT

Health and Medical Care Consent: I voluntarily consent to and authorize Cheyenne Health and Wellness Center, its employees, agents and affiliates, to provide such medical care (including evaluation, diagnostic procedures, and medical treatment) as may be deemed necessary and appropriate by my physician, his/her designees. CHWC periodically conducts training programs for health care professionals. These persons may be observing or participating in CHWC's treatment programs. They will be under the direction of supervised licensed professionals. I understand that I have the right to refuse to have trainers or students participate in my care.

Wyoming Immunization Registry: I understand that the state of Wyoming maintains an immunization registry. The benefits of the registry are to prevent duplication of immunizations, provide timely notification of immunizations due, and to serve as a backup in case you lose your record of vaccination(s). Immunization records are only accessible by authorized health care providers, and schools.

☐ I authorize CHWC to enter information regarding my (or my child's) immunizations into the Wyoming Immunization Registry.

☐ I choose to no longer have myself (or my child) participate in the Wyoming Immunization Registry and request that my (or my child's) immunizations be removed from the Wyoming Immunization Registry.

Printed Name of Patient: _____

Patient or Authorized Signature: _____ **Date**_____

If patient is unable to sign or is a minor, indicate relationship to patient: _____

Emergency contact information: In case of emergency who should we contact?

Name: _____ **Phone: (**) - _____ **Relationship to patient:** _____

ACKNOWLEDGEMENT OF PRACTICE'S NOTICE OF PRIVACY PRACTICE

CHWC is committed to protecting the confidentiality of your medical information and is required by law to do so. The Notice of Privacy Practices (NPP) describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. By subscribing my name below, I acknowledge that I was provided a copy of the NPP and that I have read (or had the opportunity to read if I so choose) and understand the NPP and agree to its terms.

Patient or Authorized Signature_____ **Date**_____

Initials_____ Pt#_____

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AUTHORIZATION TO DISCLOSE INFORMATION

If you would like HealthWorks (HW) to share your health information with a family member (such as spouse, parent, child, friend, lawyer or anyone else); you must first give HW permission to do so. By filling out and signing this form, you give that permission.
HW may then share your health information with the people whose names you have written in the "Contact" section.

Patient Name: _____

Street Address: _____

City, State, Zip: _____

Home Phone: _____ Alternate Phone: _____

I hereby authorize HealthWorks to disclose health information to the following contacts:

Contact #1 Name: _____ Relationship to me: _____

Street Address: _____

City, State, Zip: _____

Home Phone: _____ Alternate Phone: _____

Contact #2 Name: _____ Relationship to me: _____

Street Address: _____

City, State, Zip: _____

Home Phone: _____ Alternate Phone: _____

By signing this form, I understand that HealthWorks may discuss past, present, or future health care issues with these contacts from _____ through _____.

Start Date **End Date (not to exceed 2 years from start date)**

The information that may be disclosed or discussed is:

- ☐ All my information
- ☐ All my information (except HIV, mental health, and substance abuse)

Signature: _____ **Date:** _____

Initials_____ Pt#_____

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Service Assistance Screening

So, that we may better assist you in applying for additional services please answer the following:

- Are you currently eligible for Social Security Retirement Benefits, Social Security Disability Benefits, or other Retirement? ☐ No ☐ Yes
- Are you currently eligible for Medicaid or Medicare Benefits? ☐ No ☐ Yes..... If NO, please answer the following section

Do any of the following apply to you or anyone in your household?

☐ Uninsured child(ren) under the age of 19 ☐ Uninsured adult with children who are under 19 years of age ☐ Uninsured pregnant woman ☐ Uninsured aged, blind, and disabled ☐ Uninsured woman diagnosed with breast or cervical cancer ☐ Uninsured individual with tuberculosis ☐ Woman who recently gave birth and received benefits through the Pregnant Woman program	☐ Medicare beneficiary ☐ Client receiving SSI benefits not enrolled in Medicaid ☐ WIC ☐ CLIMB Wyoming ☐ Connections Corner ☐ Safehouse ☐ Father Factor ☐ Health Assist/Job Assist	☐ Housing assistance ☐ SNAP (food stamps) ☐ Low Income Energy Assistance Program (LIEAP) ☐ CHA utility allowance ☐ TANF (Temporary Assistance for Needy Families) ☐ Recently unemployed

If no income was indicated, please answer the following questions:

How are you supporting yourself?	
Where did you sleep last night?	
What was your last employment date?	
Where were you last employed?	
Do you intend to return to work and if so when?	
How did you get here today?	
Where did you eat your last meal?	
Do you receive any public assistance?	
Does anyone provide you money monthly to pay your expenses?	☐ No ☐ Yes, Amount of monthly payment provided $_____.___

Signature of Responsible Party: _____ **Print Patient Name:** _____

Relationship to Patient: _____ **Date:** _____

Summary

To serve you better, HealthWorks participates in the Laramie County GoalConnect Collaborative. GoalConnect is linking multiple agencies together to better serve clients, reduce duplication of efforts and decrease gaps in access to the most needed services.

Purpose and Benefits to Your Care

GoalConnect Partners want to better serve your needs through coordinating services. Sharing your individual information may reduce referrals you do not need or connect you to public programs and community service groups that may help you. It may tell providers about your health history, allergies and prescription drugs to coordinate your care. Finally, being in the system can reduce repeated paperwork.

You Choose to Participate

We ask you to sign this form to include you in the GoalConnect system. It is your choice to sign. No Provider may refuse to treat you if you do not sign. If you do not sign the form, Providers will not share your information through the database. You may cancel your authorization at any time.

Security & Privacy of Information

Federal and state laws protect the privacy of your information. GoalConnect protects your information by strictly limiting who can access the system. We require all Participating Partners their employees, agents and business associates to sign confidentiality agreements to maintain the security of your information. You will receive the HIPAA Notice of Privacy Practices, which gives you additional information about the providers' respective confidentiality policies.

Current Participating Partners of GoalConnect are:

- Cheyenne Regional Medical Center
- HealthWorks
- Peak Wellness Center, Inc.
- Needs, Inc.
- COMEA
- Connections Corner/Circles Wyoming
- Wyoming Interfaith Health Ministries (Faith Nurses)
- Family Promise of Cheyenne
- Community Action of Laramie County – Heath Care for Homeless
- Community Action of Laramie County – Kinship Support Services
- University of Wyoming Family Practice
- Behavioral Health Services CRMC
- Sage Trio
- Cheyenne-Laramie County Health Department – Family Planning

Consent Form

- I understand that by signing this form, I give permission for my provider, a GoalConnect Participating Partner, to enter my individually identifiable information in the GoalConnect system.
- I understand that my individual information could include participation in an Agency program, demographic information to include name, birth date, gender, race, social security number, address, phone number, household members, financial information, employment status, residential, health and treatment history and/or personal or family needs information.
- I have reviewed the list of current GoalConnect Partners, and I know that others may be added later. A list of Partners is available to me upon my request.
- I have received a copy of this form.
- I understand that this form will be effective unless I cancel it or GoalConnect ends. I can cancel this authorization at any time by completing a Cancellation Form, which I can get from any Participating Provider.
- I understand if I sign on behalf of someone else, I am certifying that I have authority under Wyoming law to make health care and social services decisions for that person.
- I understand I am allowing GoalConnect to share my individually identifiable information and that no Partner may access my information unless I go to that Participating Provider for services.
- I understand that it is my choice to sign and that no Provider may refuse to treat me if I do not sign.

I have read and understand the above.

Patient Name (PRINT)	Authorized Representative Relationship to Client (if applicable)
Your Signature (or Signature of Representative)	Date
HealthWorks Facility	Client DOB:
Witness	Date

HealthWorks
Credit & Collection Policy

It is the policy of HealthWorks, to provide the finest quality of health care available. In an effort to make our services available to as many patients as possible on an affordable basis, HealthWorks employs a firm payment policy. This enables us to provide the highest level of care, and be sensitive to cost containment. In an effort to be fair to all patients, HealthWorks has adopted the collection policy outlined below. Please read the policy to learn how the services from HealthWorks will be provided to you in an affordable way.

NEW PATIENTS
New patients should arrive 20 minutes before their scheduled appointment time to complete the patient information sheet. Please bring photo identification, insurance coverage information, including insurance cards, with you. New patients with insurance coverage are expected to pay deductibles, coinsurance or co-payments or any balance not covered by insurance at the time service is rendered. For your convenience, HealthWorks also accepts MasterCard, VISA, American Express and Discover cards. **If you do not have insurance, and are not on the sliding fee, a minimum fee of $117.00 will be collected at the time of service. This will be applied toward your visit.**

ESTABLISHED PATIENTS
Please bring photo identification and insurance cards with you for each visit. Patients who have large bills as a result of continuing medical care and who are unable to make full payment as a result of financial difficulties should contact our billing specialists. We can help work out payment terms to patients in financial need.

INSURANCE
The HealthWorks physician, physician assistants, nurse practitioners, dentist and pharmacy participate in a variety of insurance plans. It is the patient's responsibility to know the terms of their own plan. HealthWorks will abide by signed insurance contracts as a participating provider. Patients covered under "participating" plans will be responsible for deductible and co-payments in accordance with their specific contracts. For non-participating insurance plans, we will complete necessary insurance forms and mail as a courtesy to you. Please call your insurance company if you have questions about your coverage.

It is also very important to advise us of your insurances carrier's pre-authorization requirements regarding hospital admission, diagnostic, laboratory or other outpatient testing. We need to be aware of any specific requirements regarding where procedures can be performed according to your insurance carrier's plan. You are responsible for insuring that proper authorization is obtained prior to services being rendered on either an inpatient or outpatient basis.

We understand that questions may arise regarding your account and these should be discussed with our billing specialist. We will be happy to help you; however the arrangement of the insurance company to pay for medical care is between you and the insurance company.

WORKERS' COMPENSATION / AUTO ACCIDENTS / THIRD PARTY LIABILITY
Patients are expected to provide the date of injury, claim number, mailing address and phone number to where claims will be sent for payment. You will also need to provide your personal health insurance information if applicable. Doing so will protect you if your claim is denied. We can, in those circumstances, bill your health insurance provider. If you are on an active sliding fee scale at the time of service, HealthWorks can adjust your bill once it has been denied by the carrier to your sliding scale nominal fee. Otherwise, service charges become the responsibility of the patient.

PAYMENT ARRANGEMENTS
Patients who have established payment arrangements are required to make monthly payments to keep their account in good standing.

SLIDING FEE SCALE
As a Federally Qualified Health Center (FQHC), HealthWorks is required to provide a sliding fee scale discount to patients who meet the eligibility guidelines. This program assists people who may be unable to afford to see a provider based on family size and income. Sliding fee scale patients are those with household incomes that are 200% or below the federal poverty income guidelines. Households with incomes over 200% of the federal poverty limits will be responsible for paying 100% of the charges. The eligibility requirements are based on the federal poverty guidelines published annually by the U.S. Department of Health and Human Services.

IDENTITY THEFT PROTECTION
We will be requesting the following information at the time of service: Full legal name of patient/parent, birthdate(s), Social Security number(s), current physical address as well as valid photo identification(s).

NSF
Returned checks are subject to a minimum fee of $29.00.

COLLECTIONS
Should it be necessary to turn your account over for collection, you will be held responsible for any additional collection, court costs, or attorney fees. Account balances 60 days past due are considered delinquent.

LITIGATION
Our services are provided in good faith. The bill is between you and your doctor. For circumstances where you are required to hire an attorney for compensation, we do not accept "letters of protection" from your attorney. We would expect payment in full for services or you would need to contact our billing specialists to work out payment terms. WE WILL FILE YOUR HEALTH INSURANCE FORMS AS A COURTESY. WE IN NO WAY BECOME INVOLVED IN THIRD PARTY LIABILITY.

CHARGES FOR MEDICAL RECORDS
HealthWorks charges $25.00 for copies of medical records. Records will be mailed within 30 days of receipt of payment.

SUMMARY
If you have any questions regarding our collection policies, please contact our billing specialists to discuss them. Our representatives are familiar with most of the major insurance carriers and may be able to answer questions regarding your coverage or direct you to people who can do so.

If a problem comes up that you don't anticipate and you are unable to pay your bill, please contact our office at 307-634-7390. This will let us know that you are receiving your bill and are not making efforts to avoid payment.

Thank you for being cooperative in our collection policy and thank you for selecting HealthWorks as your provider of health care services.