

PATIENT NAME: _____ DOB: _____ / _____ / _____
First MI Last mm/dd/yyyy

ACKNOWLEDGEMENT OF POLICIES AND PROCEDURES

Thank you for choosing Cass County Health / Dental / Behavioral Health Clinic for your medical / dental and behavioral health care. Our staff values your time and we hope you will, in turn, value ours. In order to serve you better we have the following office policies for you to review and sign. Agreeing to these policies will enable us to provide better care to you in a timely and efficient manner.

PAYMENT

- All payments / copays for services performed are due at the time of service
- Eligibility for services under Illinois Medicaid will be determined prior to the start of each visit.
- You must bring your current insurance card for each appointment. If eligibility cannot be verified, you will be required to pay for the service.
- Any services not covered by Medicaid, Medicare and/or medical / dental insurance will be your responsibility to pay.
- A patient with a past due balance will be required to consult with our billing office to set up a payment plan to pay off the past due amount.
- I understand if my account is referred to a Collection Agency I will be responsible for Collection costs incurred.

SLIDING FEE SCHEDULE

- We offer a sliding fee plan to allow patients who have provided proof of income to receive services at an affordable fee. Your fee is determined by the income and size of your family.
- The sliding fee schedule is based on the United States Department of Health and Human Services Guidelines.

APPOINTMENTS

- It is your responsibility to remember your appointment. In order for us to provide a courtesy call, a current contact phone number is required. It is your responsibility to inform us of any changes.
- Staff will call to confirm appointments. You must answer, or call us back within 24 hours, or your appointment will be cancelled.
- If your phone number is disconnected or not updated or your voicemail is not working, your appointment may be filled with another patient.
- New patients will be asked to show up to their appointment 30 minutes prior to the start of their appointment to complete new patient paperwork.

TREATMENT OF MINORS

All minors must be accompanied by a legal guardian or a legal guardian must give written permission for another individual to accompany them by completing the required Proxy Form. Depending on the treatment to be provided a legal guardian may be required to be on site to give informed consent except in cases where minors may seek care as allowed by Illinois state law.

PATIENT CENTERED MEDICAL HOME

A patient centered medical home is a system of care in which a team of health professionals work together to provide all of your health care needs. We use technology such as electronic medical records to communicate and coordinate your care and provide the best possible outcomes for you. You, the patient, are the most important part of the patient-centered medical home. When you take an active role in your health and work closely with us, you can be sure that you're getting the care you need!

I understand and agree to the above written policies.

Signature

Date

Patient Name: _____ DOB: _____

CCHC PEDIATRIC PATIENT MEDICAL HISTORY (0 MONTHS – 18 YEARS)

Any problems at school? No Yes _____

Who does child live with? _____ Relationship: _____

HISTORY

Has your child been seen by another physician or pediatrician? No Yes

Name of physician / pediatrician: _____

Medications: _____

Drug / Medication Allergies: No Yes _____

Other Allergies: _____

Do you have any questions or concerns regarding your (child's) health or development? No Yes

Birth History (To be completed for children 0-12 months old)

Complications with pregnancy: _____

Birth: Vaginal C-Section Birth weight: _____ Birth Length: _____

Breast Fed: No Yes Special Diet: No Yes Appetite: Good Fair Poor

Bottle Fed: No Yes Formula Type: _____ Amount: _____ How often: _____

EXAM / TEST	Where / Year
Colon Screening:	_____
Type: <input type="checkbox"/> Fecal Occult Blood <input type="checkbox"/> Flex Scope <input type="checkbox"/> Colonoscopy	
HgbA1c (diabetes)	_____
Dental Exam	_____
Eye Exam	_____

MALE HEALTH (12 years old and up if applicable)

PSA/Rectal Exam-Where _____ Year _____

Do you perform Self Testicular Exams Yes No

Have had any urology problems? Yes No

FEMALE HEALTH (12 years old and up if applicable)

First menstrual period Age _____

Last menstrual period Date: ____/____/____

Menopause: Year _____

Miscarriages / Abortions: _____

Birth Control: None Pills Other: _____

Mammogram-Where _____ Year _____

Do you perform Self Breast Exams? Yes No

Pap Exam - Where _____ Year _____

Patient Name: _____ DOB: _____

	Self	Family History (Mother, Father, Brother, or Sister)		Self	Family History (Mother, Father, Brother, or Sister)
Alcohol or Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Hip problems	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anemia / Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease(COPD/TB, etc)	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Melanoma / Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Heart Disease/ Fever	<input type="checkbox"/>	<input type="checkbox"/>
Blood clot in leg or lung	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Infection	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Stroke / Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease / Attack	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Condition Type _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis: Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Urinary problems / Pain	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Disability: Autism			Mental Health Condition:		
Spectrum Disorder, Deaf, Blind,	<input type="checkbox"/>	<input type="checkbox"/>	Depression, Bipolar, Schizophrenia,	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual Disability, Cerebral Palsy			Anxiety, ADHD		

Hospitalization, Surgery, Serious Injury

PATIENT NAME: _____ DOB: ____/____/____

First MI Last mm/dd/yyyy

School Grade is:

- A/C Elementary A/C Jr. High A/C HS Beardstown HS
- Beardstown Grand Beardstown Gard Beardstown Jr. High BCA
- Virginia Elementary Virginia Jr. High Virginia HS Alternative School
- Pre-school or Other

***Does this child live in Cass County?**
 No Yes

*Does this child attend a Cass County School? No Yes
 *Is this child a brother or sister of a child attending a school in Cass County? No Yes

Mother's Maiden Name: _____

I, as the authorized representative/ parent/ guardian of this patient, authorize the following person(s) to transport, accompany, authorize, and consent to any x-ray, exam, medical, dental, psychiatric, or psychological diagnosis or treatment to be rendered by CCHC/CCDC staff. All providers may discuss patient's care with those listed below.

Initials	Proxy Name	Relationship to Patient	Phone#

_____ This patient (if 12 years or older) may present and receive diagnosis, treatment, and instruction without additional supervision

Initials _____ Myself ONLY

Initials **105 ILCS 129:** <http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=2935&ChapterID=17>

The School Health Center Act -Requires the SHC to list the available services, giving parent the option to opt out of certain services. Minor Consent laws still apply.

The Cass County School Health Center (CCSHC) consists of a seamless partnership of trusted local agencies dedicated to the health and well-being of your child. The partnership includes; A Physician, Nurse Practitioner or Physician Assistant, Dentist, Dental Hygienist, Nurse and Mental Health Counselor are available, based on schedules, to provide primary health care, dental care, psychosocial services and nutritional consultation to ALL students enrolled.

- Available services may include, but are not limited to:
1. Physical examination, health assessments, screening for health problems
 2. Diagnosis and treatment of acute illness and injury
 3. Diagnosis and management of chronic illness
 4. Health education and promotion. Outreach health promotion /prevention workshops will be offered
 5. Immunizations
 6. Wellness promotion including smoking cessation, nutrition, weight management
 7. Reproductive health care including: gynecological examinations with PAP smears, STD education, testing, and treatment, HIV/AIDS education, counseling / testing, and contraceptive services
 8. Laboratory tests including throat cultures, complete blood counts, mono spots etc.
 9. Mental Health counseling services
 10. Dental examination and treatment
 11. Referrals to other linkage agencies for services not provided at Cass County School Health Center

410 ILCS 210/1, et seq. <http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1539&ChapterID=35>

PARENTAL/GUARDIAN CONSENT

The aforementioned child has my consent to receive services offered at the Cass County School Health Center (CCSHC) located in Cass County Illinois, by its contracted providers. I have been informed of and understand the scope of services which may be provided. I also understand that a parent, legal guardian, or student who is permitted under Illinois law to consent on his or her own behalf has a right to refuse any health care services. I also understand that although I am encouraged to be present for appointments, it is not required and that by signing below, I am authorizing the Health Center to provide services to my child in his/her best interest.

I further understand that under Illinois law, a minor over age 12 has the same capacity as an adult to consent to certain health services and no parental permission is required for such services.

I consent to the release of relevant health information and medical records in connection with treatments to the School Health Center and its collaborating partners to facilitate my child's health needs. I further authorize the School Health Center to release information regarding my child's treatment to third party payors or others for billing, program management and evaluation in accordance with federal and state laws and regulations regarding confidentiality.

I understand that if my child is 12 or older they can receive mental health/substance abuse services at the CSSHC without my consent. Per 405 ILCS 5/3-5A-105(a), they may receive up to eight 90-minute sessions for mental health services. By law, a child under age 12 will not be allowed to receive mental health/substance abuse services without parental consent.

This authorization will remain in effect unless specifically revoked in writing.

⇒ _____
Representative / Parent Guardian Signature Date

Office Use Only: Certification of Unaccompanied Minor Status

Cass County Health Department Authorization
Departamento de Salud del Condado de Cass Autorización
Cass County Health Department Authorization

Patient's Name - PLEASE PRINT El Nombre del Paciente Nom du Patient – LETTRE MOULÉES	Patient's Date of Birth Fecha de Nacimiento del Paciente Date de naissance du patient	Patient's Street Address La Dirección del Pacient Adresse du Patient	City Ville	State État	Zip Code Code postal
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I hereby authorize the use or disclosure of protected health information about me as described below.
 Yo por la presente autorizo el uso y revelación de la información protegida de salud acerca de mí describieron como abajo.
 Par la présente, j'autorise l'utilisation ou divulgation d'informations protégées sur ma santé tel que décrit ci-dessous.

I authorize Cass County Health Department to disclose:
 Yo doy autorización al Departamento de Salud del Condado de Cass para revelar información acerca de los siguientes:
 J'autorise le Cass County Health Department à divulguer:

- Physical / Dental Exam;** Examen Físico / Dental; Examen physique / dentaire
- TB Skin Test;** Prueba Tuberculosis; Test sur la tuberculose
- Vision / Hearing Screen;** Exam Vista/ del Oído; Test de la vue / d'audition
- Lead Screen;** Examen del Plomo; Test de plomb
- Immunization Record;** Vacunas; Carnet de vaccination
- Hemoglobin /Hematocrit test;** Cheque del hierro en su sangre; Test d'hémoglobine /hématocrite
- Appt Date & Time;** Fecha/Hora de las citas; Date de rendez-vous & Heure
- Other;** Otros; Autre: _____

TO: (check one); Información puede ser revelada a: (cheque uno); À: (check one) **A-C Central School District;** Distrito de la Escuela de A-C Central **Beardstown Christian Academy;** Escuela de Beardstown Christian Academy **Beardstown School District;** Distrito de la Escuela de Beardstown **Trinity Lutheran School;** Escuela de Trinity Lutheran **Virginia School District;** Distrito de la Escuela de Virginia **Other;** Otros; Autre _____

The information may be used or disclosed for each of the following purposes: For the maintenance of school records / Verification of excused absences

Esta información puede usarse y ser revelada para cada uno de los propósitos siguientes: Para conservar los registros de escuela / Para comprobar la ausencia dispensada de la escuela
 L'information peut être utilisée ou divulguée dans le but suivant: Pour la mise à jour des dossiers scolaires /Pour la verification d'absences

I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.

Entiendo que la información usada o revelada puede ser revelado otra vez por la persona(s) o la clase de persona(s) lo recibiendo y que no protegido por las regulaciones federales de la confidencialidad.
 Je comprends que l'information utilisée ou divulguée peut être sujet à une re-divulgation par la (les) personne(s) ou classe de(s) personne(s) recevant ces informations et ne sera plus protégé par les régulations fédérales privées.

I understand that I may revoke this authorization by notifying the Privacy Officer in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any affect on actions taken by Cass County Health Department in reliance on it before I revoked it.

Entiendo que puedo revocar esta autorización notificando al Oficial de la Confidencialidad al escribirle de mi deseo para revocarlo. Sin embargo, yo entiendo que si revoco esta autorización, no tendrá ningún afecto en acciones tomadas por el Departamento de Salud antes de yo lo revoqué
 Je comprends que je peux révoquer cette autorisation en avisant l'Officier sur la vie privée par écrit . Toutefois, Je comprends que si je révoque cette autorisation, il n'y aura aucune conséquence sur les actions prises par le Cass County Health Department en dépendance avant révocation.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

Entiendo que puedo negarme a firmar esta autorización y que al negarme no afectará mi habilidad de obtener el tratamiento, ni el pago, ni mi elegibilidad para beneficios.
 Je comprends que je peux refuser de signer cette autorisation et que mon refus de signer n'affectera pas mon abilité d'être traité ou paiement ou mon éligibilité pour avantages.

I understand this authorization will expire on (check and complete one): _____,20____,or **Upon withdrawal from school or high school graduation.**

Entiendo que la autorización expirará en (cheque y completará uno): _____,20____,or **En el acontecimiento de la graduación de la preparatoria, la terminación del nivel más alto del grado ofreció (para esos no ofreciendo graduación de la preparatoria), o dejan de asistir en la escuela.**
 Je comprends que cette autorisation expirera (cochez et complétez): _____,20____,ou **Lors du retrait de l'étudiant (enfant) de l'école ou lors de la graduation.**

This form must be fully completed before signing
 Esta forma debe ser completada antes de firmar
 Ce formulaire doit être complété complètement avant d'être signé

<input checked="" type="checkbox"/> _____ Signature of Patient or Legal Guardian La Firma del Paciente o Representante Personal Signature du Patient ou Gardien legal	_____ Date of Signature La Fecha de la Firma Date de la signature	_____ PLEASE PRINT Name of Person Signing this Authorization if not Patient Nombre del Representante Personal(Si es aplicable) Le nom de la personne qui signe cette autorisation si ce n'est pas le patient
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