PATIENT FIRST NAME:______________________MI:___LAST NAME______________________

Social Security Number:_____-____-_____ Date of Birth: ____/____/____

Home Phone:___________________Cell Phone:____________________

Sex assigned at birth: ☐Male ☐Female

Gender Identity: ☐Male ☐Female ☐Transgender Male / Female to Male ☐Transgender Female / Male to Female ☐Other ☐Choose not to disclose
Sexual Orientation: ☐Lesbian or Gay ☐Straight (not lesbian/gay) ☐Bisexual ☐Something else ☐Don't know ☐Choose not to disclose

Address:____
(Street Address) (City) (State) (Zip)

Mailing Address (if different):____
(Street Address) (City) (State) (Zip)

Appointment reminders / Confirmations / Special Notices / Sharing Information

Email and text messaging allows us to exchange information efficiently. At the same time, we recognize that email and text messaging are not a completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly during transmission. If you would like us to send email and/or text messages that contains your health information, please provide the following information to authorize CCHD to communicate with you and other health care providers for your medical care and treatment.
** Complete the following only if email / text correspondence is being authorized:

Email to send me information: _______________________Phone Number to send me texts: _________________

*If you prefer not to authorize the use of email / text messaging we will continue to use U.S. Mail or telephone to communicate with you.

YOUR PRIMARY CARE DOCTOR IS:_________________ ☐Dr. Royeen ☐Dr. Curry ☐Emily Eichelberger NP
YOUR DENTIST IS:____ ☐Dr. Watson

Ethnicity	☐Not Hispanic / Not Latino ☐Hispanic / Latino ☐Unknown / Not Reported

Race	☐American Indian/Alaska Native ☐Black/African American ☐More than one race ☐Other Pacific Islander	☐Asian ☐White ☐Native Hawaiian ☐Declined

Marital Status: ☐Single ☐Married ☐Legally Separated ☐Divorced ☐Widowed

Are you a: Student? ☐No ☐Yes **Veteran?** ☐No ☐Yes **Migrant Worker?** ☐No ☐Yes

Housing: ☐Own ☐Rent ☐Income Based / Public Housing ☐Living with Friends / Family ☐Homeless

What is the approximate annual household income?__________Family Size____☐ Refused to Report

Does patient need an interpreter? ☐No ☐Yes **-**Spanish / French / Sign Language

If patient is under the age of 18 does the parent/guardian need an interpreter?
☐No ☐Yes **-**Spanish / French / Sign Language

Does patient have a Power of Attorney For Healthcare/ Advance Directive / Do-Not-Resuscitate order / Court Ordered Guardian? ☐No ☐Yes *If yes please provide us with a copy.

<u>EMERGENCY CONTACT INFORMATION:</u>

NAME:____

Relationship:____________________________________ Phone Number:________________________

PATIENT NAME:____DOB:__________________

RESPONSIBLE PARTY INFORMATION *Person to be billed if other than patient

First Name:_____________________MI:_____Last Name:________________________Suffix:______

Social Security Number:_____-______-______ Date of Birth: ____/____/____ Sex: ☐ Male ☐Female

Address:____
(Address) *(City)* *(State)* *(Zip)*

Phone Number: __________________________

INSURANCE INFORMATION: Check all that apply

☐Medicaid ☐Allkids ☐Medicare ☐Private Insurance ☐Selfpay ☐Sliding Fee

Name of Policy Holder:___________________________________

Social Security Number of Policy Holder:___________________________Date Of Birth:_______________

Place of Employment: _________________________Work Telephone Number:______________________

Name of **Medical Insurance**:____

Policy Number:______________________Member Number:________________Effective Date:__________

Name of **Dental Insurance**:____

Policy Number:______________________Member Number:________________Effective Date:___________

All clients have the right to treatment by the Cass County Health Department (CCHD) without discrimination to age, race, color, religion, sex, sexual orientation or national origin.

The above information is true and correct to my knowledge.

I accept full responsibility for my/my child's care and treatment and release the CCHD and staff of any and all liability for any adverse results that may occur due to my refusal to follow the recommended plan of treatment.

I authorize the CCHD to provide service to me and to release necessary information to bill, process and receive payment of Medical / Dental Benefits (private insurance, Medicare, or Medicaid, etc.), for Medical and Professional Services Rendered.

PATIENT RIGHTS AND RESPONSIBILITIES: I understand it is my responsibility to read and follow the information contained in this notice. All clients have the right to treatment by CCHD without discrimination to age, race, color, religion, sex, sexual orientation or national origin.

NOTICE OF PRIVACY PRACTICES: My signature below also indicates that I have been offered a copy of CCHD's "Notice of Privacy Practices." I understand it is my responsibility to ask any questions I may have.

Client (or Parent) Signature:____**Date:**__________

How did you hear about us? ☐Newspaper ☐Friend/Family ☐Billboard ☐Radio ☐Other_________________

PATIENT NAME:____DOB:_________________

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:__________________

Consent to Release Information to Designated Family Member or Caregiver

The names listed below are allowed to have information released to them from Cass County Health Department with the undersigned consent.

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

☒Signature_______________________________Date______________

*This consent may be revoked at any time upon written request.

PATIENT NAME:____DOB:__________________

Please complete this form if you are a Medicare Patient

MEDICARE PATIENTS -MSP

I am receiving Medicare based on: ☐ Age ☐ Disability ☐ End Stage Renal Disease

I am currently employed: ☐No ☐Yes
Name and address of my Employer____

I have a spouse who is currently employed: ☐No ☐Yes
Name and address of spouse's Employer____

Do you have Group Health Plan on your own or your spouse's current employment?
☐No ☐Yes-Both ☐Yes-Self ☐Yes-Spouse

MEDICARE LIFETIME SIGNATURE FORM STATEMENT
TO PERMIT PAYMENT OF MEDICARE BENEFITS TO CASS COUNTY HEALTH DEPARTMENT

I request payment of authorized Medicare benefits or on my behalf for any services furnished me by The Cass County Health Department. I authorize any holder of medical and other information about me to be released to Medicare and its agents any information needed to determine these benefits or benefits for related services.

⇨Patient Signature:___________________________Date:_____________

OR if patient is unable to sign Please Print:

_____________________________________ ⇨___________________________________ _________

PRINT Representative / Parent / Guardian Name AND RELATIONSHIP | **Signature Representative / Parent / Guardian** | **Date**

If patient is less than 18 years of age – please complete this page

PATIENT NAME:____**DOB:**__________________

School Attending: **School Grade:**_______

☐ 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#*

______ ______________________ ______________________ ______________________
Initials *Proxy Name* *Relationship to Patient* *Phone#*

______ ______________________ ______________________ ______________________
Initials *Proxy Name* *Relationship to Patient* *Phone#*

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

______ 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 CCSHC 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.

⇨______________________________ ____________**AND**⇨______________________________ ____________
Representative / Parent Guardian Signature **Date** **Patient Signature (age 12 or older)** **Date**

Office Use Only: ☐Certification of Unaccompanied Minor Status