Promise Healthcare

Patient Information (Please present your Photo Identification and insurance card with this paperwork)

Legal Name: First	Middle	Last	Suffix (Jr, Sr, II, III etc.)

Date of Birth: ____/____/____	Social Security #	Patient Sex as listed on Insurance/Driver's License /State ID ☐ Male ☐ Female

Street Address	Apt/Ste/Unit	City	State	Zip

Mobile/Cell Phone ( )	Home Phone ( )	Email address

Best way to contact me/leave messages (check all that apply): ☐ Phone/voicemail ☐ E-mail/Patient Portal ☐ SMS Text

Preferred Pronoun ☐ Asked but unknown ☐ He, Him, His ☐ She, Her,Hers ☐ They, Them, Theirs ☐ Ze, Hir ☐ Other ☐ Declined

How would you (patient) describe your Gender Identity:

☐ Female
☐ Male
☐ Female to Male (FTM) Transgender Male
☐ Male to Female (MTF) Transgender Female
☐ Choose not to disclose
☐ Other:_____

Sexual Orientation:

☐ Lesbian or Gay
☐ Heterosexual (or straight)
☐ Bisexual
☐ Something else
☐ Choose not to disclose
☐ Don't know

Marital Status ☐ Single ☐ Partner ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other

Preferred Language ☐ Burmese ☐ English ☐ French ☐ German ☐ Japanese ☐ Italian ☐ Spanish ☐ Guajarati ☐ Kanjobal ☐ Tigrinya ☐ Sudanese ☐ Other:

Student Status ☐ Full-time ☐ Part -time ☐ Not a Student

Responsible Person for Bill - If 'Self' leave blank

Relationship ☐ Self ☐ Parent ☐ Life Partner ☐ Spouse ☐ Other_____

Legal Name: First	Middle	Last	Suffix (Jr, Sr, II, III etc.)

Street Address	Apt/Ste/Unit	City	State	Zip

Date of Birth ____/____/____	Social Security #	

Housing and Worker Status

Homeless Status: ☐ Doubling ☐ Transitional ☐ Street ☐ Shelter ☐ Other (Homeless) ☐ Permanent Supportive Housing ☐ Not Homeless

Emergency Contact/ Relations/Role

Legal Name: First	Middle	Last	Suffix (Jr, Sr, II, III etc.)

Street Address	Apt/Ste/Unit	City	State	Zip

Mobile/Cell Phone ( )	Home Phone ( )	Relationship to Patient

Migrant Worker Status

☐ Migrant ☐ Not a Farm Worker ☐ Seasonal Worker

Race:

☐ Asian Indian
☐ Vietnamese
☐ American Indian/Alaskan Native
☐ Chinese
☐ Other Asian
☐ Black/African American
☐ Native Hawaiian
☐ Filipino
☐ Other Pacific Islander
☐ White
☐ Japanese
☐ Samoan
☐ Asian
☐ Korean
☐ Guamanian or Chamorro

Ethnicity:

☐ Hispanic
☐ Mexican
☐ Not Hispanic
☐ Mexican American
☐ Chicano
☐ Puerto Rican
☐ Cuban
☐ Spanish
☐ Other Hispanic

Veteran: ☐ Yes ☐ No

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Minor Consent for Treatment

Minor's full name: _____ Date of Birth: _____

A physician, nurse practitioner or physician assistant, dentist, dental hygienist, nurse, psychiatrist, and mental health counselor are available, based on schedule to provide primary healthcare, dental care, psychosocial services, and nutritional consultations.

Available services may include, but are not limited to:

- Physical examinations, health assessments, and/or screening for health problems
- Diagnosis and treatment of acute illness and injury
- Diagnosis and management of chronic illness
- Health education and promotion: outreach health promotion /prevention workshops will be offered
- Immunizations
- Wellness promotion including smoking cessation, nutrition, and/or weight management
- Reproductive health care including gynecological examinations, STD education, testing and treatment, HIV/AIDS education, counseling/testing, and contraceptive services
- Laboratory tests including throat culture, complete blood counts, mono spots etc.
- Mental health counseling services
- Dental examination and treatment
- Referrals to other agencies for services not provided at the School Based Health Center.

By signing below, I certify and affirm that:

The aforementioned child has my consent to receive services offered by Promise Healthcare by its 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 minor who is permitted under Illinois law to consent on his or her own behalf has a right to refuse any health care service(s). 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 Promise Healthcare 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 parent is required for such services.

I understand that if my child is 12 or older and were to receive mental health/substance abuse services from Promise Healthcare, he/she/they may receive up to eight therapy sessions without my consent. By law, a child under age 12 will not be allowed to receive mental health/substance abuse services without parental consent.

This consent shall be effective from the date of signature for one year unless I terminate it in writing or at such time that the minor turns eighteen (18) or otherwise becomes emancipated.

Parent/guardian printed full name: _____

Relationship to minor: _____

If/when I am not available, I authorize the following person(s) to accompany this child to their appointment(s) if applicable:

Full Name: _____ Relationship to Child: _____

Full Name: _____ Relationship to Child: _____

Full Name: _____ Relationship to Child: _____

Parent/guardian signature: _____ Date: _____

Patient signature (12 years or older): _____ Date: _____

STAFF USE ONLY

Received by: _____ Date Received: _____

Promise Healthcare

HIPAA Authorization Form

Who can discuss your Medical Information?

Patient Name:_____ Date of Birth: _____

About this form:

- This form allows those listed below to have information about your medical care and/or payment either verbally in person or via telephone.
- This form allows Promise Healthcare to inform those listed below (or a disaster relief organization) of your location, health or death.
- This form does **NOT** replace the 'Release of Information' form which allows for copies of medical records.

☐ I **do not** wish to authorize Promise Healthcare to discuss my medical information with anyone.

THESE PEOPLE CAN HAVE MY HEALTH INFORMATION:		
1. Name:		Relationship to you:
Phone #:	Street Address:	
City:	State:	Zip Code:
2. Name:		Relationship to you:
Phone #:	Street Address:	
City:	State:	Zip Code:
3. Name:		Relationship to you:
Phone #:	Street Address:	
City:	State:	Zip Code:

APPROVED TYPES OF INFORMATION:			
☐ All Information	☐ Appointment Information	☐ Lab Results	☐ Testing Results
☐ Billing Information	☐ Treatments	☐ Dental Services	☐ Other:_____ _____

By signing, I allow Promise Healthcare to talk about my (or my dependent's) health information to the person listed above. I understand that this form does NOT replace the 'Release of Information,' and does not allow those listed above to receive copies of my medical records.

Patient/Parent/Guardian Signature: _____ Date: _____

Promise Healthcare

HIPAA Authorization Form (cont.)

SENSITIVE MEDICAL INFORMATION TO BE RELEASED (Initial and Date Required for Each Item):

I understand that the information approved above may contain sensitive medical information that requires my specific consent in order to be discussed. By initialing each item, I specifically authorize Promise Healthcare to talk about the following sensitive topics with the people listed on this form:

☐ Mental/Behavioral Health	Initials: _____	Date: _____
☐ Alcohole/Drug Abuse	Initials: _____	Date: _____
☐ Genetics	Initials: _____	Date: _____
☐ Reproductive Care	Initials: _____	Date: _____
☐ HIV/AIDS/Sexually Transmitted Diseases	Initials: _____	Date: _____

Please Note: The following medical information of a patient 12 – 17 years of age (minor patient) is restricted as follows:

Drug/alcohol use, reproductive health, AIDS/HIV, other sexually transmitted disease(s), birth control, sexual assault, as well as any health information generated as a result of the minor patient's independent, legally authorized consent to treatment, requires the minor patient's signature to discuss.

Information in mental health or developmental disabilities will be available after the minor patient's signature, provided the minor patient has been informed and does not object to disclosure. Otherwise, Illinois law only permits limited mental health or developmental disabilities information to be available to the Minor patient's parent or guardian.

If patient is a minor, (age 12-17) Promise Healthcare requires an adult to witness the signing.

Patient/Parent/Guardian Signature:	Today's Date:
Witness Signature:	Today's Date:
Witness Name (printed):	Witness phone #:
Witness Relationship to Patient:	

This authorization will be valid as long as the patient remains a patient of Promise Healthcare unless patient designates an expiration date or revokes the authorization in writing. If patient fills out multiple versions of this form, all previous versions of this form are void and only the newest form with the most recent date of signature is accepted. If the patient is a minor at time of signature, this authorization expires upon the minor's age of majority.

Promise
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'Notice of Privacy Practices' Acknowledgement

By signing below, I acknowledge that I received a copy of the 'Notice of Privacy Practices.'

Patient/Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____

'Patient Bill of Rights' Acknowledgement

By signing below, I acknowledge that I received a copy of the 'Patient Bill of Rights.'

Patient/Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____

Promise Healthcare

Authorize to Release Protected Health Information

PERSONAL INFORMATION

Patient Name:_____Date of Birth:___/___/___ SS#: _____-_____-____

Maiden Name or Other Name (s):_____MRN: _____

Address:_____City_____State_____ZIP_____

Phone number: _____(home, cell, other) Email:_____

I Authorize: Promise Healthcare- Health Information Management (HIM)

☐ **To Send to:**
OR
☐ **To Request from:**

_____
Name of Health Care Facility, Physician, Individual, or Agency, etc.

_____
Address

_____ _____ _____
City, State, Zip Phone Number Fax

Method of Release: ☐ Mail ☐ Pick Up at HIM Department ☐ Email _____

***If you choose to receive your health information by email, then there is risk that the information in the email could be read by a third party.**

SPECIFIC RECORDS TO BE RELEASED

☐ All records
☐ Immunization records (specify date):_____
☐ Billing Records (specify dates):_____
☐ Office visit (specify dates and provider):
_____
☐ Labs
☐ Dental ☐ Other (specify):_____
☐ Date(s) of treatment:_____

If you want any of the following health information, then you must check and initial next to the category below:

☐ Alcohol/drug abuse records _____Initials

☐ Genetics _____Initials

☐ HIV/AIDS/Sexually Transmitted Diseases _____Initials

The purpose of this disclosure of information is _____
(i.e., continuing care, Insurance claim, legal counsel, etc.)

- I understand that my medical record may include information relating of sexually transmitted disease, AIDS, HIV, treatment for Alcohol and/or substance abuse
- I have the right to inspect and obtain a copy of the records that are to be disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not e protected by federal confidentiality rules.
- I understand that I may revoke this authorization at anytime. I understand that if I want to revoke this authorization, I must provide a written revocation to the HIM department of Promise Healthcare. I understand that the revocation will not apply to information that was released previously.
- This authorization will expire on the following date or event _____.If I do not specify an expiration date or event, this authorization will expire on the date of the signature below and records will only be released for services up to and including that date.
- I understand that I am entitled to a copy of this authorization
- I understand there may be a charge to obtain a copy of these records.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.
If the patient is 18 years of age or older, the patient mush sign and date the form.
If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form.
Please indicate your legal authority and include documentation of your relationship
☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)
If the patient is 17 years of age or younger, the patients parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship: ☐ Parent ☐ Legal Guardian

Signature:_____ Date Signed:_____

Consent expiration date is required if alcohol / drug abuse records are requested: _____

Printed Name of Person Signing (If not patient):_____ Phone#:_____

STAFF USE ONLY

Released by Staff Name:_____ **Type of ID verified:** _____**Date:**_____