Todays Date:_____

CHPC Christopher Rural Health Planning Corporation

PATIENT INFORMATION

Last Name:	First Name:	Middle:	Date of Birth:	Social Security #:

Street Address:	City:	State:	Zip Code:

Mailing Address: ❑Same as above	City:	State:	Zip Code:

Home Phone:	Cell Phone:	Email (Used for Patient Portal):

Preferred Language: ❑Check here if interpreter needed	Primary Care Provider:	Contact Preference: ❑Voice ❑Text	Primary Pharmacy Name:

Please complete this section if applicable:

Patient Marital Status:	Patient Employer Name:	Patient Employment Status:	Advance Directive: ❑Yes ❑No

As a Federally Qualified Health Center, we are required to collect certain information, please complete the following:

Veteran: ❑Yes ❑No	**Sex:** ❑Male ❑Female

Race (Check all that apply):	**Ethnicity:**	**Household Information:** ❑Homeless
❑White ❑Black ❑Native Hawaiian ❑Other Pacific Islander ❑Indian/Alaskan Native ❑Asian ❑Filipino ❑Japanese ❑ Korean ❑Guamanian or Chamorro ❑Chinese ❑Samoan ❑Other:_____ ❑Refuse	❑Hispanic Latino ❑Non-Hispanic Latino ❑Puerto Rican ❑Cuban ❑Other:_____ ❑ Mexican/Mexican American ❑Refuse	No. in household:_____ ❑Public Housing Annual Income:_____ ❑Check here if interested in learning about our discount programs

RESPONSIBLE PARTY INFORMATION (PERSON TO RECEIVE BILLING STATEMENT)

Last Name: ❑Same as patient	First Name:	Middle:	Date of Birth:	Social Security #:

Mailing Address:	City:	State:	Zip Code:

Telephone Number:	Driver's License #:	Relationship to patient:

INSURANCE INFORMATION (PLEASE GIVE PHOTO ID AND INSURANCE CARD(S) TO THE RECEPTIONIST)

Name of Insurance:	Subscriber No:	Group No:

Insured Name: ❑Same as patient	Last Name:	First Name:	Middle:

Patient relationship to insured:	Date of Birth:	Social Security #:

EMERGENCY CONTACT INFORMATION

Last Name:	First Name:	Middle:	Telephone Number:

Address:	City:	State:	Zip Code:

Relationship to patient:

Christopher Rural Health tries to meet your special needs. Please help us by circling or noting items you would like assistance with:

❑Sign Language/Interpreter ❑Translator ❑ FinancialAssistance ❑Other:_____

Christopher Greater Area Rural Health Planning Corporation

PATIENT CONTACT PERMISSION FORM/VERBAL DISCLOSURE

Patient Name (Print):_____ Date of Birth:_____

****Patients age 12 and older must complete this form themselves if information falls in any of the Confidentiality Laws as listed below****

Please list who we may verbally discuss your health information with: (This is a verbal release only; no copies of records will be released based solely on this form)

☐ None

Name (Parent/Legal Guardian)	Relationship to patient	Phone Number
Name (Parent/Legal Guardian)	Relationship to patient	Phone Number
Name	Relationship to patient	Phone Number
Name	Relationship to patient	Phone Number

Please note that CRHPC staff will not restrict verbal communication with either parent unless a legal court document is present in the patient's chart that specifically prohibits the release of information.

_____ _____
Signature of Patient/Authorized Representative/Parent/Guardian Date

_____ _____
CRHPC Staff Date

NOTE Records covered under Specific Confidentiality Laws WILL NOT be discussed verbally unless signed here by patient, guardian or legal representative. These include HIV/AIDS, Substance Abuse, Mental Health, Genetic Information or Communicable Diseases. **Patients age 12 and older must sign themselves****

SIGNATURE:_____

CONSENT FOR TREATMENT, FINANCIAL RESPONSIBILITY & PERSONAL REPRESENTATION

CONSENT FOR TREATMENT: I authorize the employees of Christopher Rural Health to render Medical, Dental or Behavioral Health treatment to me. Furthermore, I realize that among those who provide care to patients at Christopher Rural Health are Medical, Nursing, Dental and other healthcare students/residents/doctors in training who, unless I direct otherwise in writing, may be present to observe and/or participate in my care as part of their education/employment.

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS: I consent to the use or disclosure of my protected health information by Christopher Rural Health for the purpose of diagnosing, providing treatment, exchanging health information with other healthcare entities, obtaining external prescription history, collecting payment for my health care bills or to conduct health care operations of Christopher Rural Health.

DESIGNATION OF PERSONAL REPRESENTATIVE: For continuity of care you can designate a personal representative to assist in your health care needs should you become unable to do so. This person, any one of your choice, would have the same rights under HIPAA as yourself in regards to communication with health care staff, obtaining copies of your medical records and assisting with your financial responsibility. This is an optional decision and in no way will affect your health care at this facility. A legal form, such as a Power of Attorney, should be present in conjunction with this decision but is not required. Please ask the receptionist for a copy of the form if applicable.

NOTICE OF PRIVACY PRACTICES: I understand I have a right to review Christopher Rural Health's Notice of Privacy Practices prior to signing this document and a copy of the Notice of Privacy Practices has been offered to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Christopher Rural Health. This Notice of Privacy Practices also describes my rights and Christopher Rural Health's duties with respect to my protected health information. *"A copy of the Notice of Privacy Practices is displayed in the waiting rooms of all CRHPC facilities for patient review at any time.

FINANCIAL RESPONSIBILITY: I understand that I am financially responsible for all charges for services rendered by Christopher Rural Health. I understand that all co-pays are due at the time of service. I authorize any insurance company, including Medicare/Medicaid to pay benefits directly to Christopher Rural Health and understand that if my insurance company has not paid, I am responsible for the full amount due to Christopher Rural Health. If it becomes necessary for the account to be transferred to a collection agency for collection, I agree to pay all costs of collection including attorney fees. If you are unable to fulfill your financial obligation, please see the Community Resource Staff to inquire about our Sliding Fee Program.

NOTICE TO PARENTS OR GUARDIANS: The parent/guardian must accompany a child under the age of 18 years unless the parent/guardian has made prior arrangements for care in their absence or can be contacted by phone with verbal permission and the provider consents to this arrangement. Payment must be made regardless of who accompanies the child.

NOTICE TO DIVORCED PARENTS: The parent who brings the child to Christopher Rural Health is responsible for payment.

I certify:

1. ***That I have read or have had this consent read to me;***
2. ***That I was given an opportunity to ask questions;***
3. ***That all questions were answered to my satisfaction; and,***
4. ***That I understand this consent and accept its terms and conditions.***

Signature of Patient, Parent or Legal Guardian **Date**

PATIENT BILLING AND PAYMENT INFORMATION

Thank you for choosing Christopher Greater Area Rural Health Planning Corporation as your Community Health Care Clinic and Primary Care Provider. We are committed to providing you with quality and affordable health care. Many patients have questions regarding insurance and payments so we have provided this information.

Please read, ask us any questions and sign in the space provided.

1. **Self-Pay:** means that payment is due at the time of service. We offer sliding fee and payment plans for patients that qualify. This also means that your bill will not be filed to an insurance company.

2. **Insurance:** We participate in most insurance plans, including Medicare and Medicaid. If you are **not** insured by a plan we do business with, or **don't** have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company regarding provider participation and with any questions you may have regarding your coverage.

3. **Co-payments and deductibles:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payment and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

4. **Non-covered services:** Please be aware that some-and perhaps all-of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. Again, knowing your insurance benefits is your responsibility.

5. **Proof of insurance:** All patients must complete our patient information form before seeing the doctor. We must have a copy of your driver's license and current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim

6. **Claims submission:** After care is given, we will send a bill to your insurance company. We will help you in any way we reasonably can to help get your claims paid by the insurance company. Your insurance company may need you to supply certain information directly which is your responsibility to call the insurance company upon request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. **Coverage changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will be billed to you.

8. **Nonpayment:** If your private pay account is over 60 days past due with no payments, you will receive a letter from Trans-world to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

9. **Missed Appointments:** Our policy is that if you miss three (3) appointments without calling to cancel, you will not be given an appointment and will be seen on a walk-in basis.

10. **Billing:** Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges in the area.

Thank you for understanding our payment protocol. Please let us know if you have any questions or concerns.

I have read and understand the payment protocol and agree to follow these guidelines.

_____	_____	_____
Name of Patient (Printed)	Signature of Patient or Responsible Party	Date

CHRISTOPHER GREATER AREA RURAL HEALTH PLANNING CORPORATION
4241 STATE HIGHWAY 14 WEST, PO BOX 155
CHRISTOPHER, IL 62822
618-724-2436

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We care about our patient's privacy and strive to protect the confidentiality of our medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information and this practice is required by law to maintain the privacy of that information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

WHO WILL FOLLOW THIS NOTICE: Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment, or healthcare operations as described in this Notice. When treatment is involved any information needed to accomplish the task will be shared.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU: The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

FOR PAYMENT: We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date and codes identifying your diagnoses and treatment to your insurance company for payment.

FOR HEALTH CARE OPERATIONS: We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: we may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

OTHER USES OR DISCLOSURES THAT CAN BE MADE WITHOUT CONSENT OR AUTHORIZATION:

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To worker's compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- To the correctional institution or law enforcement official for an inmate
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

  We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may interest you.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR WRITTEN AUTHORIZATION:

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written/verbal authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written/verbal authorization. You understand that we are unable to take back any disclosures we have already made with your authorization and that we are required to retain our records for the care we have provided you.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS: You have the right to request how we should send communications to you about medical matters and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

RIGHT TO BE NOTIFIED OF A BREACH OF PHI: This practice is mandated by law to notify any patient whose protected health information is found to have been subject to a breach. This practices' Privacy Officer will perform a risk assessment of the breach to determine if patient notification is required. Based on the outcome of the risk assessment, the Privacy Officer of this practice will determine the need to move forward with the breach notification. This notification is by first class mail and will be made within 60 days of the discovery of the breach.

RIGHT TO USE, ACCESS, EXCHANGE AND COPY: You have the right to use, access, exchange and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes; information compiled for use in civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To access and copy medical information that may be used to make decisions about you, you must submit your request in writing or verbally to the Health Information Department at any CRHPC facility. If you request a paper copy of the information, we reserve the right to charge a flat fee of $6.50 for the cost of copying, mailing or other supplies associated with your request. We may deny your request to access and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

RIGHT TO AMEND: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized request for information pertaining to the appropriate portion of your record.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request restrictions regarding your medical information. The organization must comply with the requested restriction if, except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment) and the Protected Health Information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. To comply with a restriction you would need to complete a request form available from the Privacy Officer at this practice.

RIGHT TO ACCOUNTING OF NON-STANDARD DISCLOSURES: You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (ex: paper/electronically). The first list you request within a 12 month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

RIGHT TO A PAPER COPY OF THIS NOTICE: You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current notice, please request one in writing from the Privacy Officer at this practice.

YOUR INDIVIDUAL RIGHTS REGARDING YOUR MEDICAL INFORMATION; COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

CHANGES TO THIS NOTICE: We reserve the right to change this Notice. We reserve the right to make the revision or change of the Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the lower corner of the last page.

CHRISTOPHER RURAL HEALTH
PLANNING CORPORATION

Kimberly Mitroka, President/CEO

833-209-0498
www.crhpc.org
4241 STATE HWY 14 W.
PO BOX 155
CHRISTOPHER, IL 62822

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

PATIENT NAME:_____ DOB:_____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required by law to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that the practice submitted to make each of the following purposes: treatment, payment and health care operations.
- A description of each of the purposes for which this practice is permitted or required to use or disclose.
- A description of use and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization.
- Individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to file a complaint to this practice and to the Secretary of Health and Human Services if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is required to agree to a requested restriction if the requirements of the restriction are met.
    - The right to request confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to request an amendment to protected health information and that this practice is not required to agree to such an amendment.
    - The right to be notified by mail in the event of a breach of protected health information from this practice.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.
    - The right to use, exchange and access my Protected Health Information or Electronic Health Information upon my request, written or oral, in the format of my choosing.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature:_____ Date:_____

Relationship to patient (if signed by a personal representative of patient):_____