Patient Registration Form

Welcome to Shawnee Health Care - Your Health Home! We are happy you have chosen us for your care. To register, please complete this form. Several of the items below help us ensure that we are meeting the needs of the population we serve. Let us know if you have any questions or if you need help completing this form.

1. Patient Information

Legal Name: Last First Middle | Preferred Name: | Social Security Number:

Date of Birth: / / | Legal Sex: ○Male ○Female

Shawnee Health Care will send you mail to this address. We believe it's important to communicate with you, and at times, we do mail information.

Home Street Address:

City: | State: | Zip Code:

May our automated system call you about your appointments? Consent to Call ○YES ○NO Consent to Text ○YES ○NO

Home Phone: ____________ Mobile Phone: ____________

Would you like access to your lab results, medication refills, appointments, billing and secure messaging?
If yes, provide your email below and we will invite you to our patient portal.

Email Address:

Select your preferred method of communication:

○Home Phone ○Mobile Phone ○Patient Portal

2. Select the option(s) that best apply:

Relationship Status: Married Single Divorced Separated Widowed Partner

Do you see any other providers? (Please include any primary care provider, dentist, specialists)

Race (select all that apply):	Ethnicity:	Primary Language:
☐Asian ☐Native Hawaiian ☐Other Pacific Islander ☐Black/African American ☐American Indian/Alaska Native ☐White ☐Other	○Hispanic or Latino ○Not Hispanic or Latino	○English ○Quiche ○Spanish ○Arabic ○Mandarin ○Korean ○Other: ____________

Do you need a language interpreter? ○YES ○NO | Do you need a sign language interpreter? ○YES ○NO

What is this information for? Shawnee Health Care receives money from the federal government to help provide health care services, based on the information below. By providing this information, you help us continue to receive this money and provide quality health care services. Personal financial information is not released. We appreciate your help!

Family Size: | Annual Income: | ☐ I decline to report

Are you or is anyone in your family working on a farm? ○YES (move to next question) ○NO (skip next 2 questions)

(Farm work include: Orchards, vineyards, flowers, vegetables, trees, herbs, berries, dairy, poultry, and bees as well as the preparation and processing for market or delivery to storage)

In the past 2 years have you or a family member moved in order to do farm work? ○YES ○NO

In the past 2 years have you or a family member done farm work on a seasonal basis? ○ YES ○ NO

What is your housing situation today?
○I have housing ○I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, in a car, or in a park)

Are you worried about losing your housing? ○YES ○NO ○ I choose not to answer this question

MR#:________________

Are you a Veteran? ○YES ○NO	Have you ever been discharged from the Armed Services? ○YES ○ NO
Have you ever been a coal miner? ○YES ○NO	

The following questions help us provide services to the community and to better understand the needs of the populations we serve.

Which gender do you identify as?
- ○ Male
- ○ Female
- ○ Trans Man (Female-to-Male)
- ○ Trans Female (Male-to-Female)
- ○ Other: ____________
- ○ Prefer Not to Say

How do you identify your sexual orientation?
- ○ Gay or Lesbian
- ○ Straight
- ○ Bisexual
- ○ Something Else
- ○ Don't Know
- ○ Prefer Not to Say

In the past year, have you or any of your family members had difficulty or have been unable to get the following? (check all that apply)

	YES	*NO*
Food	○	○
Clothing	○	○
Utilities	○	○
Child Care	○	○
Transportation	○	○
Medicine or any Health Care need (medical, dental, vision or mental health)	○	○

	YES	*NO*
Have you recently been to the emergency room?	○	○
Have you recently been in jail, correctional facility or detention center?	○	○
We have staff that can assist you with your needs. Would you like to speak with someone?	○	○

How did you hear about us? ○Website ○Social Media ○Radio ○TV ○Printed Ad ○Brochure/Pamphlet ○Hospital ○Word of Mouth ○Community Event

What is your preferred pharmacy/location? ____________________________

What is your preferred lab? ____________________________

3. Guarantor

Guarantor is the person responsible for the patient's bill. It is always the patient unless the patient is a minor or an incapacitated adult. Guarantor is not the insurance member or head of house hold.

☐ I, the patient, am my guarantor

Guarantor Name: Last First Middle		Relationship:
Mailing Street Address: ☐ Same as patient's address		
City:	State:	Zip Code:
Phone Number:	Email Address:	

4. Emergency Contact

Please list contact information for the person you want us to contact if there is an emergency. We will identify ourselves as Shawnee Health Care.

Name: Last First	Relationship:
Home Phone:	Mobile Phone:

MR#:__________________

5. Employment

☐Unemployed ☐Not Applicable		
Employer Name:		Telephone Number:
Street Address:		
City:	State:	Zip Code:

6. Insurance

Primary Insurance Name: ☐No Insurance		☐Patient is the Policy Holder *(if checked, skip to Member ID/Group Number)*
Insurance Street Address:		
City:	State:	Zip Code:
Policy Holder: Last First		Relationship:
Date of Birth: / /		Sex: ○Male ○Female
Home Street Address: ☐Same as patient's address		
City:	State:	Zip Code:

Member ID:	Group Number:

Secondary Insurance Name: ☐Not Applicable		☐Patient is the Policy Holder *(if checked, skip to Member ID/Group Number)*
Insurance Street Address:		
City:	State:	Zip Code:
Policy Holder: Last First		Relationship:
Date of Birth: / /		Sex: ○Male ○Female
Home Street Address: ☐Same as patient's address		
City:	State:	Zip Code:

Member ID:	Group Number:

MR#:_______________

7. Consents & Acknowledgements

In order for you to become a patient, we need your consent to provide you with care. We also need you to acknowledge that we have provided you with certain important information. If you have any questions about any of this information, please do not hesitate to ask a member of our staff. It is important to us that you feel comfortable with all of this information. By signing, you are indicating that you understand the information, have been given a chance to ask questions, and are giving your consent.

CONSENT TO TREAT

I voluntarily agree to receive services by physicians, dentists and other health care providers at any Shawnee Health Care (SHC) location. I understand that I should participate in planning my care and that I have a right to refuse the advice of my healthcare provider. I am aware that SHC has students/residents being trained as doctors, nurses or other health care providers who might help care for me. These students are supervised by licensed providers.

I understand that no one can be given care at SHC without first agreeing to the care unless there is an emergency.

◯ I Accept ◯ I Decline

CONSENT TO PAY FOR SERVICE AND TREATMENT

Shawnee Health Care (SHC) participates in Medicare, Medicaid and many insurance plans and will bill your insurers if we have your current insurance information.

I agree to the release of any health information needed to process insurance claims for the health care I receive at SHC. I agree that insurance payments for these services will go directly to SHC. I understand that this agreement may not result in full payment by my insurance for the services I receive and I agree to be responsible to pay for any remaining balances.

I understand that if I do not have health insurance coverage, I am responsible for paying all charges for services and treatment by SHC. I understand that SHC offers a discount to lower income individuals and families. To receive the discount, I understand that I must apply for the program and provide information about my family size and income.

◯ I Accept ◯ I Decline

CONSENT TO SHARE MEDICAL INFORMATION AND RECORDS

I understand that Shawnee Health Care (SHC) works with other health-related agencies and shares some information with them in order to provide comprehensive care. These agencies are:

- Illinois Comprehensive Automatized Immunization Registry Exchange (ICARE) for immunization information,
- Pharmacy Benefit Managers (PBM) for your medication history, and
- Centerstone for sharing of treatment information (if I am a patient of both SHC and Centerstone).

I agree for SHC to share my health, mental health, substance abuse, and HIV treatment information and records as needed with ICARE,

◯ I Accept ◯ I Decline

NOTICE OF PRIVACY PRACTICES

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Shawnee Health Care (SHC) has our Notice of Privacy Practices available on our website and at the registration desk. This document describes in detail how information about you, the patient, can be used within our office and with others who need to know for the reasons of treatment, payment, health care operations, and as required by law. If we were to disclose your information for any other reason, we would first need your written approval.

By signing my name below, I am acknowledging that I have read, and fully understand, each of the separate paragraphs set forth above. I understand that I can revoke my consent in writing at any time.

_______________________________ Signature   _______________ Date

_______________________________ Parent/Guardian Signature   _______________ Date

SCHOOL HEALTH CENTER – PARENT/GUARDIAN INFORMATION AND CONSENTS

School Health Center locations: Your School Health Center consists of a seamless partnership of the School District and Shawnee Health Service, both dedicated to the health and well-being of your child. Our locations include:

- Marion Wellness Center: The School Health Center can see any student, family member of the student, faculty/staff, and family member of faculty/staff of Marion Unit #2 School District.
- Terrier Care: The School Health Center can see any student, family member of the student, faculty/staff, and family member of faculty/staff of Carbondale Community High School District 165 and Carbondale Elementary School District 95.

A Medical Provider (Physician, Nurse Practitioner, or Physician's Assistant), a Licensed Clinical Social Worker (LCSW) or a Licensed Clinical Professional Counselor (LCPC), and a Nutritionist are available on site to provide primary health care, counseling, and nutritional consultation. We are happy to serve as your primary care provider or on an as-needed basis when your health care provider is not available. To help with continuity of your healthcare, we will send copies of visit notes to your designated health care provider to keep them up to date with your health care needs.

Services Provided: We offer the same care that you can get at most primary care physician offices. This includes:

- Routine medical care, examinations, assessments, and screenings including emergency, preventative, acute, and chronic care
- Laboratory Testing
- School and sports physicals
- Immunizations
- Nutrition counseling
- Health education and wellness promotion including, but not limited to smoking cessation, healthy lifestyles, injury prevention, abstinence/sex education, and substance abuse education
- Referrals to a dentist
- Suturing of minor lacerations
- Counseling services
- Referrals as needed for alcohol, tobacco, and drug and substance abuse counseling
- When medically indicated, only testing for pregnancy and sexually transmitted diseases including HIV/AIDS will be performed
- Students who disclose that they are sexually active will receive STD screenings
- Students who present for Confidential Services, such as performing a urine pregnancy test, will also have the urine sent to the state lab for GC/Chlamydia testing
- Terrier Care Only: Family Planning services will be provided in the form of appropriate health education which includes abstinence

Sharing of Information with the School District: We will not share any of your health information with school officials and school officials will not share any of your health information with the School Health Center. However, you may find it convenient if you give us permission to give or exchange records with school officials so that a student's school required health records are updated and the School Health Center has accurate and complete physicals and immunization information. For example, students entering Kindergarten, 6th grade, and 9th grade must have completed school physicals with updated

immunization information before classes can be attended. Students involved in sports must have a sports physical on file to participate in practices or games.

If you would like for the School Health Center to give or exchange information with the school, please complete the section at the end of this form. You do not have to sign this release. If you do sign the release, the School Health Center will release information until the student leaves the school district or until you revoke or withdraw your permission. To withdraw your permission, you must send a request to: HIPAA Officer, Shawnee Health Service, 109 California Street, P.O. Box 577, Carterville, Illinois 62918-0577.

Consent

If you would like to allow us to release information or exchange records with school officials or allow the school to release information and exchange records with the School Health Center, please check what we can release.

☐Immunization Records ☐School Physicals ☐Sports Physical ☐Attendance Records

My child has my consent to receive services offered at the School Health Center. 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 understand that I may consent to my child being seen at the Health Center if I am not present or I may require my presence at each visit. Please check the box below to tell us how to handle your child's visits:

- ☐ My child can only be seen at the School Health Center if I am present;
- ☐ My child can be seen at the School Health Center if I am not present. I understand that I will be contacted by phone before any care is provided.

I further understand that under Illinois law, minors may have the same capacity as an adult to consent to certain medical and counseling services and no parental or guardian permission is required for such services. Shawnee Health Service's Consent for Treatment policy defines these services and is available upon request.

Child's Name: ______________________________

Signature of Parent/Guardian: ______________________________ Date: ____________________

SHAWNEE HEALTH SERVICE

Patient Request for Shawnee Health Service to Release Confidential Information

Unless you provide us with permission on this form, we cannot give your family members or friends information about your visits at our health center. Please let us know if you would like others included in your health care. One word of caution – once we give a person any information, we have no control over whether the person will keep that information private. Thank you!

☐ **Check here if you do not want anyone to receive information**

Who can we share Information with? (List their name and address) and then check what can be shared	All information	Appointments	Lab or Test Results	Medical information	Dental Information	Other - please list
1						
2						
3						
4						

We will contact you at your address and telephone number on your registration form. If you do not want us to contact you at that address or telephone number, please list where we can contact you:

____

Do you have any other requests? Please list those here:

____

Patient Name (please print): ______________________ Date of Birth: __________
Signature of Patient or Legal Guardian: ______________________ Date: __________
Relationship to Patient (if not patient): ______________________
Printed Name: ______________________