ROSALIND FRANKLIN UNIVERSITY
HealthClinics

Patient Intake Registration Form

PATIENT INFORMATION

Patient's Name: Last_____ First_____ MI_____

Date of Birth: _____

Address: _____ Apt./Suite#:_____

City: _____ State: _____ Zip: _____ Home Telephone: (_____) _____ Cell Phone: (_____) _____

Name of Employment:_____ Work Address: _____

City/State/Zip:_____ Work Phone: _____

Preferred Method of Contact: ❒ Home ❒ Cell ❒ Work ❒ Email: _____

Ethnicity: ❒ African American ❒Hispanic/Latino ❒ Caucasian ❒ Asian ❒ Other_____

Preferred Language: ❒ English ❒ Spanish ❒ Other:_____ Do you need an Interpreter? ❒ Yes ❒ No

Gender: ❒ Male ❒ Female Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed

Preferred Pharmacy: _____
(Name) (Address) (Phone)

Emergency Contact Name: _____ Phone: (_____)_____

RESPONSIBLE PARTY (Please complete if different from patient or patient is a minor)

Last Name:_____ First Name: _____ Middle Initial: _____

Date of Birth: _____

Address: _____ Apt./Suite#:_____

City: _____ State: _____ Zip: _____ Telephone: (_____) _____ E-mail: _____

Relation to Patient: ❒ Spouse ❒ Parent ❒ Grandparent ❒ Legal Guardian ❒ Other: _____

I hereby acknowledge that I am the guarantor and financially responsible for payment of all services rendered, and that I have received and I am subject to all the terms on the Financial Responsibility Agreement form.

Patient Signature (18 and older): _____Date: _____ / _____ / _____

Parent/Guardian Signature: _____ Date: _____ / _____ / _____

REFERRAL SOURCE

❒ Friend/Patient
❒ Event/Health Fair
❒ Physician/Specialist
❒External Referral
❒Staff/Student
❒Current Patient
❒ Website
❒ Social Media
❒ Other: _____

Revised 11/09/2021

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Authorization for Treatment

Name of Patient: _____ Date of Birth: _____/_____/_____

I, as the patient or responsible party (for patient named above), authorize Rosalind Franklin University Health Clinics (Health Clinic) to administer medications, immunizations, and to perform such diagnostics and medical procedures as deemed medically necessary for my care based on the judgment of the physician(s) and other health care provider(s) of the Health Clinic. I understand that I have the opportunity to discuss treatment options with the physician(s) and other health care provider(s).

Signature of Patient or Responsible Party: _____ Date: _____

Name of Patient or Responsible Party: _____

Acknowledgement of Receipt of Notice of Privacy Practices

The HIPAA Privacy Rule requires that "covered entities" (e.g. hospitals and clinics) deliver a copy of their Notice of Privacy Practices to their patients at their first visit. It also requires that we seek a written acknowledgement from our patients that we did, in fact, deliver that notice. Accordingly, the Rosalind Franklin University Health Clinics asks you to acknowledge that we delivered to you a copy of our "Notice of Privacy Practices" by signing this form. I acknowledge receipt of the Rosalind Franklin University Health Clinics Notice of Privacy Practices on the date indicated below.

Signature of Patient or Responsible Party: _____ Date: _____

Name of Patient or Responsible Party (print): _____

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Information Communication Authorization

Name of Patient: _____ Date of Birth: _____/_____/_____

As part of our efforts to deliver quality care, we may need to contact you at times when you are away from the Health Clinics. Some examples are returning your phone calls, reminding you of scheduled appointments, and notifying you of lab results or other events. We normally contact our patients between 8am and 5:30pm, Monday through Friday. In order to accommodate any request you may have, please indicate your preferences below:

Please provide the telephone number(s) that you prefer for us to use to contact you	May we leave a message at this number?
Home:	Yes or No
Work:	Yes or No
Cell:	Yes or No

Protected Health Information Release:

We recognize that our patients often prefer to involve their family members or others in their health care. One example is when that the other person accompanies you to the examination room. At other times, you might not be readily available to express your preferences. Examples of those are when you want that other person to receive status updates while you are undergoing a procedure, to pick up prescriptions or other documents for you, or get answers to billing-related questions about your care. These events would normally involve that other person hearing or seeing some of your health information. To help us better understand your preferences in this matter, please indicate below the names of those you want to be involved in your care at times when you might not be readily available:

1._____ Relationship _____

2._____ Relationship _____

3._____ Relationship _____

Signature of Patient_____ Date ____/____/____

Signature of Legal Guardian (if applicable) _____ Date ____/____/____

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Financial Responsibility Agreement

Rosalind Franklin University Health Clinics (Health Clinic) is committed to your care, and we thank you for choosing us to serve you today. As part of the treatment, you will incur costs for the services and supplies rendered to treat you. As the patient, or guarantor for the patient, you will be responsible for payment in full. Because we value you as our customer, we attempt to work with you to resolve these costs. If you have any questions related to your financial situation, please contact the Patient Financial Services Department at (847) 578-8546.

We accept most insurance plans; however, you are responsible for verifying that we are a participating member with your insurance. If you have a HMO, you have responsibility for obtaining the necessary referral(s). All copayments will be taken at the time of registration. As a courtesy, we will bill your insurance directly for payment. If there is a dispute with your insurance, we have the right to bill you prior to resolution. It is important, at each visit, you provide us with the most current information regarding your insurance.

If you do not have insurance, we are committed to providing you ways to make payment in full for services received. We accept cash, personal checks, and credit cards as forms of payment. We offer a 15% discount for payment in full at the time of service. In order to be eligible for this discount, you must have no outstanding balance due. If you are unable to make payment in full at the time of service, we will bill you for the balance due. A Financial Hardship Program is offered to qualifying individuals based on income level, as well. Discounts are based upon your level of income relative to Federal Poverty Guidelines. If you believe you may qualify, please ask for an application.

As a final alternative, we use a collection agency to collect on past due balances. If you fail to make payment on your account, you will be responsible for the costs incurred by the collection agency. This includes, but is not limited to, the fee assessed by the agency to the Health Clinic for their services and legal fees, if necessary.

By signing this acknowledgement, you (or guarantor for the patient) accept responsibility for payment of the services and supplies rendered by the Health Clinic. You certify that you have read and understand your responsibilities and provided accurate and complete information.

Signature of Patient or Responsible Party: _____ Date: _____

Name of Patient or Responsible Party: _____

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Request for Provider to Complete Forms Policy

Dear Valued Patient,

The clinicians and staff of Rosalind Franklin University Health Clinics are committed to providing you with the highest quality care possible. It is the policy of Rosalind Franklin University Health Clinics that requests for providers to complete forms for work, or other roles that might include, but not be limited to, ability / fitness to drive or operate machinery, other fitness for duty assessments, parking disability requests etc. cannot be entertained on a first-time visit. Such requests can significantly impact the ability of Rosalind Franklin University Health Clinics to provide quality care to you, our patient.

Effective March 1, 2021, Rosalind Franklin University Health Clinics will require of an established patient – provider relationship which, for the purpose of this matter, will be defined as a minimum of three (3) visits between patient and provider. Clinicians reserve the right to exercise their professional judgement according to individual circumstances but in general as a first-time patient there should not be an expectation that paperwork is going to be completed.

If you have any questions or concerns about this change, please feel free to discuss with our Patient Service Representatives or your assigned provider. We look forward to continuing to work with you.

Sincerely,

Rosalind Franklin University Health Clinics

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Notice of Privacy Practices

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

INTRODUCTION

Rosalind Franklin University Health Clinics is required by law (the federal HIPAA Privacy Rule) to maintain the privacy of protected health information (PHI) and to provide you with this notice of our legal duties and privacy practices regarding PHI. We are required to abide to the terms of this notice. We may change at any time the terms of this notice for all PHI we maintain. If we do so, we will revise this notice to reflect the new terms and have it available for you upon request.

PERMITTED USES AND DISCLOSURES

At times, other federal laws and the laws of the State of Illinois impose stricter limits on the use and disclosure of PHI than the HIPAA Privacy Rule. In those cases, the HIPAA Privacy Rule states that we must follow the laws that provide you with the greater amount protection over your PHI. Subject to those stricter limits, we may use and disclose your PHI as follows:

Treatment. We may use or disclose your PHI for treatment activities of a health care provider. For example, we may use your PHI to provide medical care to you and we may disclose PHI to another physician who is providing medical care to you.

Payment. We may use or disclose your PHI for activities relating to obtaining reimbursement for the health care services you received. In addition, we may disclose your PHI for similar activities of another health care provider or a group health plan that relates to you. For example, we may use your PHI to bill you or your insurance company, as appropriate, for services rendered.

Health Care Operations. We may use or disclose your PHI for certain activities relating to the operation of the Health Clinics as a health care provider. In addition, we may disclose your PHI for those activities relating to the operation of another health care provider or a group health plan with which you have a relationship. For example, we may use and disclose your PHI for activities relating to quality assessment, training of health care professionals, fraud and abuse detection, and compliance programs.

Other Permitted Uses and Disclosures. We may use and disclose your PHI so long as certain conditions that relate to your privacy and public necessity are met:

* to **Persons Involved in Your Care or Payment of Your Care**, but you will have the opportunity to object and, if you do object, we will abide by your wishes. * to **Business Associates** who perform functions for us and who have promised in a written agreement to safeguard your PHI.
* as **Required by Law**, so long as the specifics of the use or disclosure is no more than that required by the law.
* for **Public Health Activities**, such as reporting disease, injury, and vital statistics.
* to **Report Adult Abuse, Neglect, and Domestic Violence**, under certain conditions. * to a **Health Care Oversight Agency** that oversees the health care system.
* for **Judicial and Administrative Proceedings**, so long as there is a lawful court order or other legal demand.
* for certain **Law Enforcement Purposes**, such limited PHI relating to fugitives, crime victims, suspicious deaths, crimes on our premises, and crimes in emergencies.
* certain information about **Decedents** to coroners, medical examiners, funeral directors, and organ/tissue donation entities.
* for **Research Purposes**, so long as an oversight board approves the request under strict guidelines, is preparatory work that does not leave the Health Clinics, or is about decedents.
* to **Avert a Serious Threat to Health or Safety**, as necessary under the circumstances. * for certain **Specialized Government Functions**, such as Armed Forces personnel, national security activities, correctional facilities, and government health benefit programs.
* for **Workers' Compensation** programs.
* to contact you and provide information **Useful Information**, such as appointment reminders and health-related benefits and services that may be of interest to you.

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* to contact you about the Health Clinics efforts to **Raise Funds**, but you have the right to opt out of receiving these fundraising communications.
* a **Limited Data Set**, which deletes certain information about you, so long as the PHI is only used for research, public health, or health care operations purposes and the recipient agrees in writing to safeguard your PHI.

Your Written Authorization. Other than the uses and disclosures discussed above, we will not use or disclose your PHI without your written authorization. This includes uses or disclosures made for marketing purposes, that constitute a sale of your PHI, and of most psychotherapy notes. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure that occurred prior to this Health Clinic receiving your revocation.

YOUR RIGHTS

A brief summary of your rights are as follows. For additional information regarding these rights, you may contact the office listed at the end of this notice.

Access. You have the right to inspect and obtain a copy of your PHI records. To do so, you must seek access in writing. A reasonable fee may be charged for copying and postage, if applicable.

Amendment. You have the right to seek an amendment to your PHI records. To do so, you must make your request in writing. Even if the PHI record is determined to be accurate and complete, you have the right to submit a statement of disagreement.

Accounting. You have the right to obtain a list of certain disclosures that occurred regarding your PHI. To do so, you must seek your accounting in writing. Some disclosures would not be mentioned on that list, such as those associated with treatment, payment, and health care operations and disclosures you personally authorized in writing.

Further Restrictions. You have the right to seek further restrictions on how we use or disclose your PHI. To do so, you must make your request in writing. Although we are not required to agree to most of those requests, we will review them and, if we do agree, we will document it and abide by it. We are required to agree to a request to restrict a disclosure of your PHI to a health plan for payment or health care operations purposes when the PHI relates to a health care item or service for which we have been paid in full by you or by other alternative means.

Confidential Communications. You have the right to request that we communicate with you using alternative means or at alternative locations. To do so, you must make your request in writing. If the request is reasonable, we will accommodate it.

Copy of this Notice. You have the right to receive a paper copy of this notice upon request, even if you previously agreed to receive this notice electronically.

File a Complaint. You may file a complaint with us and to the U.S. Department of Health and Human Services if you believe we have violated your privacy rights and we will not retaliate against you in any way. To file a complaint with us, you should contact the office listed at the end of this notice.

Notice of Breach. You have the right to receive notifications of breaches of your unsecured PHI.

FURTHER INFORMATION

If you have any questions, desire to file a complaint, or seek further information about matters contained in this notice, you may contact:

Martin Yorath
Privacy Officer
Rosalind Franklin University Health Clinics
3471 Green Bay Road
North Chicago, IL 60064
Tel: (847) 578-8436