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

Promise Healthcare

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 minor to their appointment(s) if applicable
Name:_____ Relationship_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

Parent/guardian signature: _____ Date: _____

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

STAFF USE ONLY: Verbal Consent Section (*ONLY if verbal consent is obtained)

☐ Verbal consent obtained by phone. Parent/guardian was informed of the nature of services and gave permission for treatment. Two staff witnesses present.

- **Name of Person Giving Consent:** _____
- **Relationship to Patient:** _____
- **Date & Time of Consent:** _____

Witness #1 (Printed Name & Title): _____ Signature: _____ Date: _____
Witness #2 (Printed Name & Title): _____ Signature: _____ Date: _____

Promise
Healthcare

'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: _____

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Authorization to Verbally Discuss Health Information Form

Who can Discuss your Health Information?

Patient Name:_____Date of Birth: _____

IMPORTANT – PLEASE READ

- This form allows Promise Healthcare to **verbally discuss** health information in person or by telephone only.
- This form does **NOT** authorize release of written medical records. A Release of Information (ROI) from would be required to release written records.
- **Illinois law gives minors ages 12–17 the right to control certain health services.**
- Promise Healthcare follows HIPAA and Illinois law regardless of who signs this form.

Please note: This form includes a **second page**, which must be reviewed. Certain types of **sensitive health information require additional consent** and are addressed on page 2.

Listing someone on this form does not automatically allow disclosure of all health information. Under **Illinois law**, patients ages **12–17** have the right to consent to certain services, and **the minor patient's consent may be required**, even if a parent or guardian is listed or has signed. More information on page 2

☐ I do **NOT** authorize Promise Healthcare to discuss my health information with anyone.

The people that 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: **Check all that apply (subject to legal restrictions)**			
☐ Billing Information	☐ Appointment Information	☐ Lab Results or diagnostic Testing results	☐ Treatment Information
☐ Dental Services	☐ Other (Specify):_____ _____ _____		☐ All Information legally permitted

SENSITIVE HEALTH INFORMATION – ADDITIONAL CONSENT REQUIRED

I understand that the information approved above may include **sensitive health information** that requires **specific authorization** before it may be discussed. By initialing and dating each item below, I authorize Promise Healthcare to verbally discuss the selected sensitive topics with the individuals listed on this form, **only as permitted by federal and Illinois law**.
Important: Selecting "All Information" on previous page does not authorize disclosure of sensitive information unless the applicable item below is initialed and dated and disclosure is permitted by law.

Illinois Minor Consent: When Illinois law allows a minor to consent independently to a service, **only the minor may authorize disclosure** of information related to that service.
For minors ages 12–17, minor authorization (initials and signature) is required to discuss information related to *(list not all-inclusive)*

- Drug or alcohol use or treatment
- Reproductive health care
- HIV/AIDS and sexually transmitted diseases (STDs/STIs)
- Outpatient counseling or therapy services
- Any care provided under the minor's independent legal consent

When parental consent is permitted by law, a **parent or legal guardian may authorize disclosure**, subject to legal restrictions.

Please select all additional sensitive information you wish to release. In order to be released it must have initial and date.
**For patients 12-17, the items marked with an asterik (*) may require the minor patients's authorization if selected for release.*

Mental/Behavioral Health

- **Psychiatric / Mental Health Treatment**
  (e.g., psychiatric diagnosis, psychiatric appointments, medication management, inpatient or intensive treatment)
  Initials: _____ Date: _____

- ***Counseling / Therapy Services** *(e.g., outpatient counseling)*
  Initials: _____ Date: _____

☐	*Alcohol/Drug Abuse	Initials:_____	Date:_____
☐	Genetics	Initials:_____	Date:_____
☐	*Reproductive Care	Initials:_____	Date:_____
☐	*HIV/AIDS/Sexually Transmitted Disease	Initials:_____	Date:_____

Authorization Signatures

By signing below, I acknowledge that I have read and understand this authorization. I understand that this authorization allows **verbal discussion only** of the health information identified above, **only as permitted by federal and Illinois law**.
I understand that disclosure:

- Depends on **who has legal authority to consent** for the service
- For Minors: Requires the **minor's signature** when Illinois law allows a minor (ages 12–17) to consent independently and **may not be authorized by a parent or guardian** for services subject to minor consent rights. Promise Healthcare requires an **adult witness** (non parent) when the patient is a minor (ages 12–17).

Patient / Parent / Legal Guardian Signature

Signature: _____ Date: _____
Printed Name: _____ Relationship to Patient (if applicable): _____

Minor Patient Signature *(required when the minor independently consented to the service)*

Signature: _____ Minor Initials:_____ Date: _____
Printed Name: _____

Witness (Required for Minors Ages 12–17)
Signature: _____ Date: _____
Printed Name: _____ Relationship to patient:_____ Phone #: _____

This authorization remains valid while the patient is receiving services at Promise Healthcare unless an earlier expiration date is specified or the authorization is revoked in writing. If multiple versions of this form are completed, **only the most recent signed version is valid**. If the patient is a minor at the time of signature, this authorization **expires when the patient reaches the age of majority (18yo) or emancipated**.

Promise Healthcare

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice applies to all Promise Healthcare locations.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record.

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We may ask you to make the request in writing.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record.

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications.

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share.

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information.

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice.

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you.

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated.

- You can complain if you feel we have violated your rights by contacting us using the information on the last page of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your preferences about what we share. If you have a clear preference in the situations below, let us know and we will follow your instructions. You have the right to decide whether we share information with your family, close friends, others involved in your care, or in a disaster-relief situation.

If you cannot tell us your preference—for example, if you are unconscious—we may share information if we believe it is in your best interest, or when necessary to prevent a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission: marketing purposes**,** sale of your information**, or** most sharing of mental health notes

In the case of fundraising:

We may contact you for fundraising efforts, but you can tell us not to contact you again.

Other Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you.

We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

- We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.
- We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.
- The examples used in this Notice of Privacy Practices are illustrations only and not meant to be a complete list.

How else can we use or share your health information?

- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see: https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.
- Help with public health and safety issues.
- We can share health information about you for certain situations such as the following: Preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law.

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Respond to organ and tissue donation requests.
- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director.

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests.

We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share your health information when required by a court or administrative order, or in response to a subpoena.
HIPAA does not override other laws that provide greater privacy protections.
If federal or state law requires stronger protections, we must follow those laws in addition to HIPAA.
Certain types of information—such as genetic test results, mental health records, HIV/AIDS test results, educational records, and information from federally assisted alcohol or substance abuse treatment programs—have additional legal restrictions on how they can be used or disclosed.

Other:

- Records related to reproductive health services are subject to enhanced privacy protections under HIPAA's Final Rule. We will not disclose such information without your explicit authorization unless required by law.
- Substance Use Disorder (SUD) treatment records are protected under 42 CFR Part 2. These records cannot be disclosed without your written consent, except as permitted by law.
- Records related to reproductive health services are subject to enhanced privacy protections under HIPAA's Final Rule. We will not disclose such information without your explicit authorization unless required by law.
- You may request additional restrictions on disclosures related to reproductive health and SUD services.
- We will comply with enhanced HIPAA protections for reproductive health information and 42 CFR Part 2 requirements for SUD records.

Our Responsibilities

We are required by law to protect the privacy and security of your health information and will notify you promptly if a breach may have compromised it. We must follow the duties and practices in this notice and provide you a copy. We will not use or share your information beyond what is described here unless you give us written permission, which you may revoke at any time by notifying us in writing.

Changes to the Terms of This Notice

We may change the terms of this notice, and any updates will apply to all information we have about you. The revised notice will be available on request, in our office, and on our website.
If you have questions or need more information about this Notice of Privacy Practices, please contact Promise Healthcare's Privacy Officer at 217-600-7000 ext. 238.

Promise Healthcare

Patient Bill of Rights

Promise Healthcare works with you to exceed your expectations. We respect your rights to healthcare access, equity, and safety, and your privacy is our priority. Your rights, your responsibilities, and our pledges to you are listed below.

You have the right to:

- Receive respectful care regardless of your sex, age, race, religion, color, national origin, sexual orientation, or any other personal characteristics, including your primary source of payment, insurance status or ability to pay.
- Be treated with consideration for your emotional, spiritual, and cultural needs.
- Be fully informed of available services at Promise Healthcare, including after hours and emergency care and fees for all services.
- Expect reasonable continuity of care and have a provider who manages your care.
- Request a second opinion when you believe it is necessary.
- Know the names and positions of people involved in your care by official name tag or personal introduction.
- Have a reasonable choice of providers and information about your options. You can change providers if you are dissatisfied with your care using our procedure for changing providers. Please ask the front desk for help.
- You have the right to receive information in a way you can understand, including free interpreter services, sign-language services, disability communication aids, or assistance such as a wheelchair or interpreter to help you access care.
- You have the right to understand your health information and participate in decisions about your care, including giving informed consent before any procedure, as required by Illinois law.
- Be made aware of any unanticipated outcomes.
- Fully take part in the decision-making process about your care. You may have parents, guardians, family members, civil union partners, or other individuals that you choose to be involved.
- Refuse a recommended treatment, to the extent allowed by law, and be informed of the risks associated with and potential consequences of refusing to be treated.
- Expect that your health record will be kept confidential. For more information about your right to privacy, please review your HIPAA and Notice of Privacy statements.
- Ask and receive an explanation of any charges made by Promise Healthcare, even if they are covered by insurance.
- Complete an advance directive for end-of-life care. Please let your care team know if you are interested in learning more about advance directives.
- Express any complaints or concerns through our Compliatric hotline: 1-888-MY COMPLY.

As part of our contract with you, we pledge to:

- Provide you with ethical treatment by caring and qualified healthcare providers.
- Provide services that are available to you as you need them.
- Provide emergency coverage and provider availability on call, 24 hours a day, 7 days a week by calling our office number. When the office is closed, the provider may consult with you by phone.
- Always deal with you honestly and openly.
- Provide you with financial help based on a sliding-fee scale. This is dependent upon your income.
- Provide you with a confidential and detailed explanation of your bill of services.
- Participate in measures to always ensure patient safety.

You have a responsibility to:

- Arrive on time for scheduled appointments and tell us if you are going to be late. If you are late, we cannot guarantee your appointment. Call us at least 24 hours in advance if you need to cancel or reschedule.
- Provide us with at least 48 hours' notice when you or a family member needs medications or a prescription.
- Follow all rules and regulations posted within Promise Healthcare.
- Speak and behave respectfully to Promise Healthcare staff and other patients.
- Respect the privacy and confidentiality of other patients.
- Turn off cell phones in clinical areas.
- Provide us with all needed information so we can keep an accurate file for you. This includes reporting any changes to your address, telephone number, status of advance directives, and if necessary, financial status.
- Pay your bills at the time of service including co-payments and deductibles or arrange a payment plan if needed.
- Provide honest and complete information about your health concerns, past health medical history, medications, and unexpected changes in your health so that we can provide you with the highest level of care.
- Provide us with medical records upon request.
- Ask questions if you do not understand any information or instructions we give you.
- Develop a treatment plan with your care team and follow it to the best of your ability. Be honest about what you have been able to do (or not do) when seen in follow-up. If you are unable to follow a treatment plan, we will do our best to help you find out why to change the plan or correct the problem if possible.
- Supervise children that are in your care.

PLEASE NOTE: Making harassing, offensive, or intimidating statements or threats of violence could result in your removal from Promise Healthcare. If you are removed from one of our offices, you are considered removed from all Promise sites.