promise healthcare

***Promise Healthcare, dedicated to improving the health of the community through treatment, prevention, and education.***

**DISCLAIMER: As a federally qualified health center (FQHC), we are required to request the information below. We realize that this is very personal Information. Therefore, we want you to know your answers will be held in the strictest confidence. The information collected is used only as a total from our database, so it in no way identifies a specific individual or family. The information collected helps to shape future programs and services to be made available at our clinics as well as on local, state, and federal levels. Thank you for your participation.**

## Fill out this form to Register or Update your information as a Promise Healthcare patient – (*Expires in 1 year from date signed)*

| **Today's Date:** | **Promise Healthcare Provider:** |
|---|---|

## Patient Information (Please Print):

| **Circle One:** Miss Ms. Mrs. Dr. Mr. | **Last Name:** | **First Name:** | **Middle Name:** | **Suffix:** Circle One Jr. Sr. Other _____ |
|---|---|---|---|---|
| **Former Name:** | **Preferred Name:** | **Social Security #:** | **Birthdate:** | **Sex Assigned at Birth:** Male Female |

| **Billing Street Address:** | **City:** | **State:** | **Zip Code:** | **Country:** | **County:** |
|---|---|---|---|---|---|
| **Home Address (if different):** | **City:** | **State:** | **Zip Code:** | **Country:** | **County:** |

| **Home Phone:** | **Work Phone:** | **Cell phone:** |
|---|---|---|
| **Email Address:** | | |

| **Gender Identity: (Circle One)** | **Sexual Orientation: (Circle One)** | **Marital Status: (Circle One)** | **Patient Notification/Contact Preference *(Circle All that Apply):*** |
|---|---|---|---|
| Female | Lesbian or Gay | Single | Phone Call – Home/Cell/Work/All |
| Male | Heterosexual (Straight) | Married | Text Message |
| Female-to-Male (FTM) *Transgender Male* | Bisexual | Legally Separated | Email |
| Male-to-Female (MTF) *Transgender Female* | Something else | Divorced | Patient Portal |
| Choose not to disclose | Choose Not to Disclose | Life Partner | Don't Call Home/Work |
| Other: _____ | Don't Know | Widowed | Leave Message – Yes/No |
| | | Decline to Specify | |

| **Race: (Circle all that apply)** | | **Ethnicity: (Circle One)** | **Student Status: (Circle one)** |
|---|---|---|---|
| American Indian/Alaskan Native | Other Pacific Islander | Hispanic/Latino | Full Time |
| Black/African American | White | Not Hispanic/Latino | Part Time |
| Native Hawaiian | Asian | Unknown/Decline to Report | Not a Student |
| Decline to Report | | | |

**Preferred Language: (Circle All that Apply)**

| | | | | |
|---|---|---|---|---|
| English | Italian | German | Tigrinya | Decline to Answer |
| Japanese | Mandarin Chinese | French | Burmese | Spanish |
| Sudanese | Other: _____ | | | |

**Prompt Pay Discount:**

***It is the policy of Promise Healthcare to encourage patients to promptly pay for services; Promise Healthcare offers a 30% discount for the prompt payment of amounts due. Promise Healthcare considers prompt payment to be*** payment made on the date of service.

- This discount is offered to patients who ***do not have private health insurance*** are considered full-pay, self-pay patients.
- Payment is requested from the client at the time of service, and the flat rate discount is given, if the patient pays in-full for the visit.

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## Person Responsible for Bill

| Last Name: | First Name: | Middle Name: | Previous Last Name: |
|---|---|---|---|
| Social Security # | Date of Birth: / / | Relationship: ☐ Self ☐ Parent ☐ Life Partner ☐ Spouse ☐ Other: _____ | |
| Street Address: | City: | State: | Zip Code: | Country: | County: |

## Employer Information

| Employer Name: | | | | | |
|---|---|---|---|---|---|
| Employer Street Address: | City: | State: | Zip Code: | Country: | County: |
| Occupation: | Employment Status: (Circle One) Full Time Part Time Active Duty Retired Not Employed Self Employed | Work Phone: | Retirement Date: / / | | |

## Emergency Contact / Next of Kin

| Last Name: | First Name: | Relationship: | Phone Number: |
|---|---|---|---|
| Street Address: | City: | State: | Zip Code: |

## Insurance Information: Card MUST be given to Front Desk Representative and Co-Pay paid at Visit

Primary Insurance:
Medicare Medicaid Blue Cross Blue Shield Molina United Healthcare Other:

| Name of Policy Holder: | Birthdate of Policy Holder: / / | Relationship: |
|---|---|---|

Secondary Insurance:
Medicare Medicaid Blue Cross Blue Shield Molina United Healthcare Other: _____

| Name of Policy Holder: | Birthdate of Policy Holder: / / | Relationship: |
|---|---|---|

## Housing and Worker Status

| Homeless Status: (Circle One) | Migrant Worker Status: (Circle One) | Have you ever served in the Armed Forces: (Circle One) |
|---|---|---|
| Doubling Up Street Not Homeless Transitional Shelter Unknown Permanent Supportive Housing | Migrant Not a Farm Worker Seasonal Worker | No Yes |

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**Sliding Fee Scale Discount Information and Purpose:**

Promise Healthcare maintains a standard procedure for qualifying patients for sliding fee scale discounts for services provided. Sliding fee scale discounts are available to patients with all incomes at or below 200% of the federal poverty guidelines. Sliding fee scale discounts apply to all directly provided Promise Healthcare services, and for all in-scope services, provided by agreement by non-Promise Healthcare providers.

**Purpose:**

To reduce and/or eliminate financial barriers to care for medically underserved populations.

## Sliding Fee Income Table 2021 - *Circle One Box*

| # of Persons in Household | Household Income | Sliding Scale A Nominal Fee* $10 per visit | Sliding Scale B $25 per visit | Sliding Scale C $35 per visit | Sliding Scale D $45 per visit | 100 % Full Pay |
|---|---|---|---|---|---|---|
| 1 | Annual | $0.00 - $12,880.00 | $12,881.00 - $19,320.00 | $19,321.00 - $22,540.00 | $22,541.00 - $25,760.00 | $25,761.00 + |
| | Per Month | $0.00 - $1,073.00 | $1,074.00 - $1,610.00 | $1,610.00 - $1,878.00 | $1,879.00 - $2,147.00 | $2,148.00 + |
| | Per Week | $0.00 - $ 247.00 | $248.00 - $371.00 | $372.00 - $432.00 | $433.00 - $494.00 | $495.00 + |
| 2 | Annual | $0.00 - $17,420.00 | $17,421.00 - $26,130.00 | $26,131.00 - $30,485.00 | $30,486.00 - $34,840.00 | $34,841.00 + |
| | Per Month | $0.00 - $1,452.00 | $1,453.00 - $2,177.00 | $2,178.00 - $2,540.00 | $2,541.00 - $2,903.00 | $2,904.00 + |
| | Per Week | $0.00 - $334.00 | $335.00 - $501.00 | $502.00 - $585.00 | $586.00 - $668.00 | $669.00 + |
| 3 | Annual | $0.00 - $21,960.00 | $21,961.00 - $32,940.00 | $32,941.00 - $38,430.00 | $38,431.00 - $43,920.00 | $43,921.00 + |
| | Per Month | $0.00 - $1,830.00 | $1,831.00 - $2,745.00 | $2,746.00 - $3,203.00 | $3,204.00 - $3,660.00 | $3,661.00 + |
| | Per Week | $0.00 - $421.00 | $422.00 - $ 632.00 | $633.00 - $737.00 | $738.00 - $842.00 | $843.00 + |
| 4 | Annual | $0.00 - $26,500.00 | $26,501.00 - $39,750.00 | $39,751.00 - $46,375.00 | $46,376.00 - $53,000.00 | $53,001.00 + |
| | Per Month | $0.00 - $2,208.00 | $2,209.00 - $3,313.00 | $3,314.00 - $3,865.00 | $3,866.00 - $4,417.00 | $4,418.00 + |
| | Per Week | $0.00 - $508.00 | $509.00 - $ 762.00 | $763.00 - $889.00 | $890.00 - $1,016.00 | $1,017.00 + |
| 5 | Annual | $0.00 - $31,040.00 | $31,041.00 - $46,560.00 | $46,561.00 - $54,320.00 | $54,321.00 - $62,080.00 | $62,081.00 + |
| | Per Month | $0.00 - $2,587.00 | $2,588.00 - $3,880.00 | $3,881.00 - $4,527.00 | $4,528.00 - $5,173.00 | $5,174.00 + |
| | Per Week | $0.00 - $595.00 | $596.00 - $893.00 | $894.00 - $1,042.00 | $1,043.00 - $ 1,191.00 | $1,192.00 + |
| 6 | Annual | $0.00 - $35,580.00 | $35,581.00 - $53,370.00 | $53,371.00 - $62,265.00 | $62,266.00 - $71,160.00 | $71,161.00 + |
| | Per Month | $0.00 - $2,965.00 | $2,966.00 - $4,448.00 | $4,449.00 - $5,189.00 | $5,190.00 - $5,930.00 | $5,931.00 + |
| | Per Week | $0.00 - $682.00 | $683.00 - $1,024.00 | $1,025.00 - $1,194.00 | $1,195.00 - $1,365.00 | $1,366.00 + |
| 7 | Annual | $0.00 - $40,120.00 | $40,121.00 - $60,180.00 | $60,181.00 - $70,210.00 | $70,211.00 - $80,240.00 | $80,241.00 + |
| | Per Month | $0.00 - $3,343.00 | $3,344.00 - $5,015.00 | $5,016.00 - $5,851.00 | $5,852.00 - $6,687.00 | $6,688.00 + |
| | Per Week | $0.00 - $769.00 | $770.00 - $1,154.00 | $1,155.00 - $1,346.00 | $1,347.00 - $1,539.00 | $1,540.00 + |
| 8 | Annual | $0.00 - $44,660.00 | $44,661.00 - $66,990.00 | $66,991.00 - $78,155.00 | $78,156.00 - $89,320.00 | $89,321.00 + |
| | Per Month | $0.00 - $3,722.00 | $3,723.00 - $5,583.00 | $5,584.00 - $6,513.00 | $6,514.00 - $7,443.00 | $7,444.00 + |
| | Per Week | $0.00 - $856.00 | $857.00 - $1,285.00 | $1,286.00 - $1,499.00 | $1,500.00 - $1,713.00 | $1,714.00 + |

**For each additional household member add:**

$4,540.00 to Annual Income

$4,378.33 to Monthly Income

$87.31 to Weekly Income

**Sliding Fee Scale is based upon total gross household income and the number of persons residing in the household.**
**Effective 03/01/2021**

## READ AND SIGN THIS SECTION

I, the patient or parent/guardian of this patient, have the legal responsibility and the right to obtain treatment and further:

- Understand this consent is good for one year from the date indicated below.
- Allow the health care Provider to give the treatment needed. This care may include but is not limited to:
  - Radiology to diagnose a problem
  - Taking samples of blood which may look for contagious diseases such as Hepatitis and HIV/AIDS
  - Taking samples of body fluids or body tissue
  - Giving medicine, immunizations and vaccines
- We will not discuss mental health, development disabilities, alcohol/drug abuse, genetics, or HIV/STDs/AIDS without an additional release form.
- Allow my Provider to treat in emergencies if it may save my/this patient's life or health.
- Agree that care at Promise emphasizes care coordination and communication into what we, as a team, deem best for the patient.
- Understand that I have the right to refuse any recommended treatment(s) that I do not agree with,
- **Understand that copay/payment in full is due at the time of service.**
- Understand Promise accepts Medicare, Medicaid, and most major commercial insurances.
- Authorize Promise Healthcare to release to Medicare/Medicaid/Insurance, the private health information necessary to process my/this patient's claim(s).
- Agree that Promise will file claim and complete the steps to collect insurance payment.
- Authorize Medicare/Medicaid/Insurance payment to be paid directly to Promise.
- Agree that if Medicare/Medicaid/Insurance doesn't pay the claim in full, **I am responsible for any remaining balance**.
- If patient copay and/or outstanding balance cannot be paid at time of service, and the nature of the visit is not non-emergency as determined by Promise triage policy, the appointment may be re-scheduled.
- Understand Promise will assess a fee for returned checks. After two returned checks, cash or debit/credit card will be the only acceptable means of payment.
- Agree to call at least 24 hours before the patients scheduled appointment to reschedule or cancelled. If calls are made in less than 24 hours, documentation will be made within the patient's chart.
- After **three NO-SHOWS**, patients will be placed on a walk in and wait status (except for same day appointments, children under the age of 2, and potentially a child under the age of 19 (Under the discretion of the Clinical Director).
  - A written copy of the No Show Policy is available to all medical patients.
- **For Pediatric Patients**: Illinois Immunization Registry (I-CARE): I-CARE, or Illinois Comprehensive Automated Immunization Registry Exchange, is a web-based immunization record sharing application developed by the Illinois Department of Public Health. The application allows public and private health care providers to share the immunization records of Illinois residents with other physicians statewide. If you refuse to share your child's immunization history to I-CARE, please let your in-take person know to obtain Opt Out of Registry Form.

**Sign (Patient/Parent/Guardian):_____ Date: _____**

## Please agree you have received and read the Notice of Privacy Practices by signing below

| | |
|---|---|
| Patient Signature: | Date: |
| Print Name: | Signature of Parent, Guardian, or Patient's Representative (if applicable): |
| Please describe your legal right to act on behalf of the patient: | |

**COMPLAINTS:**

If you believe your privacy rights have been violated, you may file a complaint with us. All complaints must be given in writing on the form provided by Promise Healthcare. To obtain a form, contact the Site Manager at (217) 356-1558 . You also may file a complaint with the U. S. Department of Health and Human Services Office for Civil Rights. *You will not be penalized for filing a complaint.*

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## WHO CAN HAVE YOUR HEALTH INFORMATION?

Please fill out this form. It will tell us which family members and friends have your permission to haveyour health information.

| Patient Name: | Date of Birth: |
|---|---|

**ABOUT THIS FORM:**

- Let those listed below have information about your medical care of payment
- Informs those listed below or a disaster relief organization of your location, health or death

**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: |

**PLEASE SIGN HERE:**

By signing below, I allow Promise Healthcare to talk about or release my health information with the people listed above.

**Mark All You Approve:**

☐ **All Information**

☐ **Billing Information** ☐ **Appointment Information** ☐ **Lab results** ☐ **Testing Results**

☐ **Treatment(s)** ☐ **Dental Services**

☐ **Other:** _____

***Please note: We will not discuss mental health, developmental disabilities, alcohol/drug abuse, genetics, or HIV/AIDS/STDs with an additional sign release form.**

| Patient/Parent/Guardian Signature: | Today's Date: |
|---|---|

**Your permission expires in one year unless cancelled in writing.**

*Revised – Effective 04/14/2021*