SIU MEDICINE

SIU Center for Family Medicine - Lincoln
109 3rd Street, Lincoln, IL 62656-2604
Phone: 217.735.2317 Fax: 217.651.8254

Dental and Medical Services
Located at the Logan County Department of Public Health

Federally Qualified Health Center (FQHC) - A collaboration with the Logan County Health Department and Abraham Lincoln Memorial Hospital

Responsible Party: (If someone other than the patient)

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

Address:_____

City, State, Zip:_____

Home Phone:_____ **Work Phone:**_____ **Ext:**_____ **Cell:**_____

Date of Birth:_____ **Email Address:**_____

Patient Information:

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

Address (If different than above):_____

City, State, Zip:_____ **Date of Birth:**_____

Home Phone:_____ **Cell:** _____

Gender Identity: ○ Male ○ Female ○ Transgender Male (Female to Male)

○ Transgender Female (Male to Female) ○ Other ○ Decline/No Response

Sexual Orientation: ○ Straight ○ Gay/Lesbian ○ Bisexual ○ Something Else

○ Don't Know ○ Decline/ No Response

If a child: Is patient a DCFS/Foster Care Client: Yes:_____ **No:**_____

Patient is: ○ Illinois Medicaid/All Kids ○ Self Pay

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Medicaid/All Kids Policy #:_____

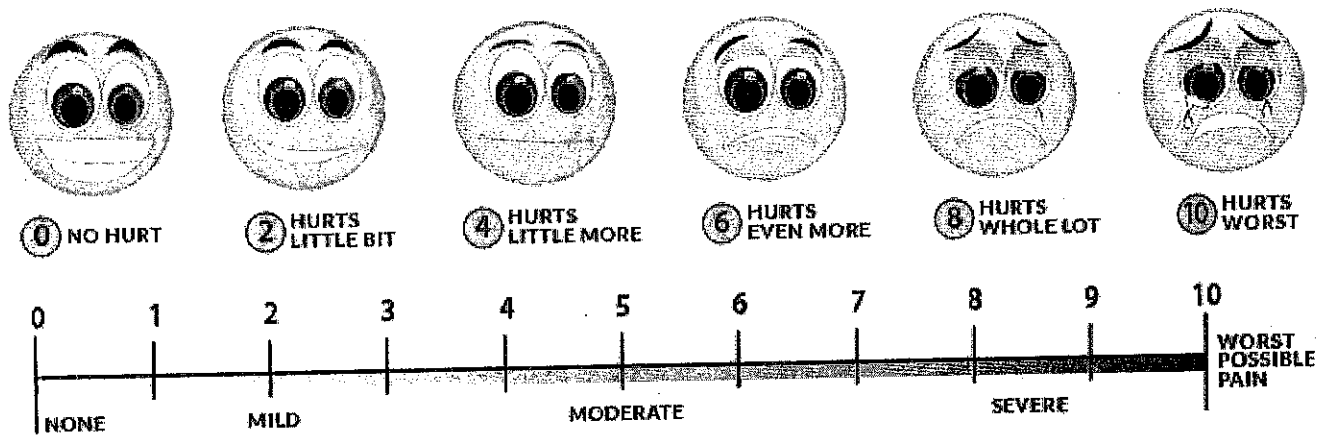
Preferred Pharmacy:_____

Veteran: ○ **Yes** ○ **No**

Race: _____ **Ethnicity:** _____ **Language:** _____

Marital Status: ○ **Single** ○ **Married** ○ **Divorced** ○ **Separated** ○ **Widowed**

If in any pain, please rate. Circle One:



Please explain:

_____

_____

_____

_____

_____

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Medical History for Dental Clinic

Although dental personnel primarily treat the area in and around our mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you take could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions. Please circle the appropriate response.

*Do you have a primary doctor? Yes No If so, who? _____
*Have you ever been hospitalized or had a major operation? Yes No
*Have you ever had a serious head or neck injury? Yes No
*Are you taking any medications? Yes No If so, what? _____
*Do you take, or have you taken Phen-Fen or Redux? Yes No
*Have you ever taken Fosamax, Boniva, Actonel
or any other medications containing bisphosphonates? Yes No
* Are you taking any herbal supplements? If so, What? _____
*Are you on a special diet? Yes No
*Do you use tobacco? Yes No
*Do you use controlled substances? Yes No
*Do you need to pre-medicate? Yes No
*Are you pregnant or trying to get pregnant? Yes No
*Are you taking oral contraceptives? Yes No

*Are you allergic to any of the following?

Aspirin? Penicillin? Codeine? Acrylic? Metal? Latex? Anesthetics?
If any other allergies, please list:

_____

Do you have, or have you had any of the following? (Circle Any That Apply)

ADD/ADHD	Cerebral Palsy	Fainting Spells/Dizziness
AIDS/HIV	Positive Chemotherapy	Frequent Cough
Alzheimer's Disease	Chest Pains	Frequent Diarrhea
Anaphylaxis	Cold Sores/Fever Blisters	Frequent Headaches
Anemia Congenital	Heart Disorder	Genital Herpes
Angina	Convulsions	Glaucoma
Anxiety	Cortisone Medications	Hay Fever
Arthritis/Gout	Dementia	Heart Attack/Failure
Artificial Heart Valve	Depression	Heart Murmur
Artificial Joint	Development/Learning Delay	Heat Pace Maker

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Asthma
Autism
Blood Disease
Blood Transfusion
Breathing Problems
Bruise Easily
Cancer
High Cholesterol
Intellectual Disability
Leukemia
Lung Disease
Mitral Valve Prolapse
Parathyroid Disease
Radiation Treatment
Rheumatic Fever
Sensory Issues
Sinus Trouble
Stomach/Intestinal Disease
Thyroid Disease
Tumors/Growths

Diabetes
Drug Addiction
Easily Winded
Emphysema
Epilepsy/Seizures
Excessive Bleeding
Excessive Thirst
Hives/Rash
Irregular Heartbeat
Liver Disease
Lupus
Osteoporosis
Parkinson's Disease
Recent Weight Loss
Rheumatism
Shingles
Sleep Apnea
Stroke
Tonsillitis
Ulcers

Heart Trouble/Disease
Hemophilia
Hepatitis A
Hepatitis B
Hepatitis C
Herpes
High Blood Pressure
Hypoglycemia
Kidney Problems
Low Blood Pressure
Mental Disorder
Pain in Jaw Joints
Psychiatric Care
Renal Dialysis
Scarlet Fever
Sickle Cell Disease
Spina Bifida
Swelling of Limbs
Tuberculosis
Venereal Disease

Have you had any serious illness not listed above? If yes, explain:

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Statement or Consent for Health Services

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the office of any changes in medical status. I hereby give my consent to all visits necessary for patient above to receive an oral evaluation, dental treatment, follow-up and maintenance treatment. I also give my consent for the release of information of health conditions to official agencies and or private doctors.

Signature of Patient, Parent, or Guardian:

_____ **Date:** _____

Patient, Parent or Guardian Name Printed:

_____ **Date:** _____

In Case of an emergency, please notify:

_____ **Phone number:** _____

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SIU MEDICINE CENTER FOR FAMILY MEDICINE	Policy:	Lincoln Dental Cancellation and No Show Policy		
	Concentration:	Site Operations	Contact Person:	Dental Director
	Unit:	Clinical	Adopted:	9/1/2018
	Location:	Lincoln - Dental	Revised:	

Purpose: No-shows, late shows and cancellations inconvenience those individuals who need access to medical care. The purpose of this policy is to minimize disruptions in the scheduling process, disruptions in the delivery of care, and to provide quality care in a timely manner.

Definitions:

24 Hour Cancellation: All dental appointments require a 24 hour cancellation. A message can be left for the dental staff 24 hours a day, 7 days a week by calling the Logan County Department of Public Health at (217) 735-2317 ext. 314. If no cancellation call is received 24 hours prior to the appointment time, it will be considered a no-show.

Release from Dental Services: A first time adult patient who no-shows for an appointment will not be rescheduled for 6 months for any future appointments. Established patient families who have 3 no-shows or cancellations less than 24 hours prior to the appointment time will not be scheduled for 1 year from the last no-show/canceled appointment date. This rule will apply for all members of the family. ***No appointments will be made with the dental clinic for services after a patient has been released from the practice.***

Confirming Appointments: Patients must verbally confirm all scheduled appointments. If appointments are not verbally confirmed, then the appointment will be cancelled and the time given to another patient.

Contact Information: It is your responsibility to keep all contact information up to date with the dental clinic. If we are unable to contact you, we reserve the right to cancel your appointment.

IMPORTANT INFORMATION FOR ALL CLIENTS

Patients are required to produce their current insurance card at time of service. This is your form of payment. If you are a cash client, full payment is expected at time of service. We reserve the right to cancel your appointment if a current insurance card is not available at time of service.

I understand and agree to the above mentioned policies:

Patient/Parent/Legal Guardian Signature:

_____ Date:_____

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Our HIPAA Pledge To You

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care that we maintain, whether created by facility staff of your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office. We are required to:

*Keep medical information about your private
*Give you this notice of our legal duties and privacy practices with respect to medical information about you.
* Follow the terms of the notice that are currently in effect.

Changes To This Notice

We may change our polices at any time. Changes will apply to medical information we already hold, as well as new information, after the change occurs. Before we make a significant change in our polices, we will change our notice and post the new noting in waiting areas and exam rooms. You can receive a copy of the current notice at any time. The effective date is listed just below the title. You may obtain a copy of the current notice each time you register at our facility for treatment.

How We May Use And Disclose Medical Information About You

We may use and disclose medical information about you for **treatment** (such as sending medical information about you to another health care facility or to a specialist as part of a referral); **to obtain payment for treatment** (such as sending billing information to your insurance company of Medicare); **to support our health care operations** (such as comparing patient date to improve treatment methods). We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without prior authorizations. We will also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances or in response to valid judicial or administrative orders.

To provide appointment reminders: We may disclose limited health information to provide you with appointment reminders such a voicemail, or electronic messages, post cards or letters. We may disclose medical information about you to a friend or family member who is involved in your medical care, or to disaster relief authorities so that your family can be notified of your

location and condition. Our workers will used their professional judgment in determining what they disclose, and to whom, based on their evaluation or your best interests.

Other Uses of Medical Information

In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or discloser, you can later revoke that authorization by notifying us I writing of your decision.

Your Rights Regarding Medical Information About You

In most cases, you have the right to look at or get a copy of medical information that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we amend the records, by submitting a request in writing that provides your reason for requesting the amendment. We may deny your request to amend a record if the information maintained by us; or if we determine that the record is accurate. You may appeal, in writing, a decision by us not to amend a record.

You have the right to a list of those instances where you have disclosed medical information about you, other than for treatment, payment, health care operation or where you specifically authorize a disclosure, when you submit a written request. The request must state the time period desired for the accounting, which much be less than a 6 year period and starting after April 14, 2003. You may receive the list in paper or electronic form. The disclosure list request will be charged according to our cost of producing the list. We will inform you of the cost before you incur any costs.

If this notice was sent to you electronically, you have the right to a paper copy.

You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing to the specific way or location for us to use to communicate with you.

You may request, in writing, that we not use or disclose medical information about you for treatment, payment, or health care operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request in an emergency. We will consider your request but we are not legally required to accept it. We will inform you of our decision on your request.

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Acknowledgement of Receipt of HIPAA Notice of Privacy Practice

I acknowledge that I have received a copy of this Clinic's HIPAA Notice of Privacy Practices.

Patient Name (Print):_____

Patient Signature: _____

Or

Parent or Guardian: _____

Authority of Guardianship or person Representative to sign for patient (circle one):

Parent Guardian Power of Attorney Other

Please Note: It is your right to refuse to sign this HIPAA acknowledgement.

Office Use Only

I tried to obtain a written acknowledgement by the individual noted above, but could not be obtained for one of the following reasons:

_____Am emergency prevented us from obtaining the HIPAA acknowledgement.

_____A communication barrier prevented us from obtaining the HIPAA acknowledgement.

_____The individual is unwilling to sign the HIPAA acknowledgment.

Staff Signature: _____Date:_____

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Parental Permission Form/ Proxy

PRINTED NAME OF PARENT/GUARDIAN: _____

PRINTED NAME OF PATIENT/CHILD: _____

As parent or guardian of the above named patient/child, I give permission to the following individuals to bring my child in for health care visits and sign in my stead for immunizations and other service.

_____ Date: _____

Parent/Guardian Signature

PLEASE PRINT:

NAME: _____

RELATIONSHIP: _____

NAME: _____

RELATIONSHIP: _____

NAME: _____

RELATIONSHIP: _____

NAME: _____

RELATIONSHIP: _____

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SIU MEDICINE
FORWARD. FOR YOU.

SIU Medical Record #_____

AUTHORIZATION TO VERBALLY RELEASE MEDICAL INFORMATION TO PERSONS INVOLVED IN MY CARE

Patient Name _____ Date of Birth:_____
PLEASE PRINT
Address:_____ Daytime Phone:_____
City:_____ State:_____

I hereby give SIU HealthCare my permission to release my medical information to the individual(s) specified below, upon their request. Methods of release may include verbal discussions or updates about my medical treatment, medications, or condition as requested. The purpose for these disclosures is to enable the person/s below to assist me in maintaining my health, and to participate in my medical care.

_____ _____ _____
Name Relationship to Patient Date

The information disclosed may include matters regarding mental health, developmental disability, alcohol or drug abuse and infectious diseases, including HIV, and medical correspondence. Please check and initial the box for which you will authorize disclosure of information; and sign below.

- ☐ _____Mental Health
- ☐ _____Developmental Disability
- ☐ _____Alcohol or Drug Abuse
- ☐ _____Infectious Diseases Including HIV
- ☐ _____Genetic Testing
- ☐ _____Other / Dental

I understand that I may revoke this authorization at any time by notifying SIU HealthCare in writing, but the revocation will not affect any actions which they have taken prior to the receipt of the revocation. I understand that this authorization will continue until I revoke it. SIU HealthCare may request a new authorization form be completed periodically.

I understand this authorization must be filled out completely, signed and dated in order to be processed.

I hereby authorize the use or disclosure of my individually identifiable medical information as described above. I understand and acknowledge that the confidential healthcare information disclosed and used pursuant to this Authorization may be subject to re-disclosure by the person or organization authorized to receive the information and may no longer be protected by federal privacy regulations upon re-disclosure.

FORM MUST BE COMPLETED BEFORE SIGNING

_____ _____ _____
(Signature of Patient or Patient's Legal Representative) Date of Birth Date

_____ _____
(Signature of Witness) Date

Printed Name of Patient's Representative:_____
Relationship to Patient:_____

This form should be scanned into the patient's EHR record as well as the authorized person's name entered into the Centricity Business (CB) banner to alert appropriate staff of authorization.

Revised 8/09; 1/10; 12/14
(HIPAA Policy: 1.200 Auth Verbal Release)
Revised & Approved by Legal and Breach Committee: 1 /2015
Approved by Quality & Safety Committee: 2/17/15

(Facsimile reproductions of the signatures are acceptable)

Financial Application

SIU Center for Family Medicine, with clinics located in Springfield at 520 N. 4th St, Phone: 217-545-8000; in Quincy at 611 N. 12th St., Phone 217-224-9484 and at 330 Vermont Street, Suite 100, Phone 217-222-8440; in Jacksonville at 345 W. State Street, Phone 217-245-5111; in Lincoln at 109 Third Street, Phone 217-735-2317; and in Decatur at 102 West Kenwood Avenue, Phone 217-872-3800

Responsible Party Information Are you head of household (HoH)? ( ) Yes ( ) No			
Name (First, Middle, Last)		Date of Birth	Social Security #
Home Address	City State	Home Phone #	Cell Phone #
Employer's Name	Job Title	Date of Employment	Employer's Phone #

Spouse's Information (If Applicable)			
Name (First, Middle, Last)		Date of Birth	
Employer's Name	Job Title	Date of Employment	Employer's Phone #

List Dependents (If Different From Tax Return, Please Explain)

Name	Date of Birth	Relationship

Have you applied for Public Aid? YES NO If Public Aid denied you, you must provide a copy of the denial.

Income: You must provide documentation for each item and provide a copy of your federal tax return or paycheck stubs for the last 3 months

Responsible Party Income			Spouse's Income (If Applicable)		
Wages (Monthly)	$		Wages (Monthly)	$	
Farm/Self-Employment	$		Farm/Self-Employment	$	
Public Assistance	$		Public Assistance	$	
Social Security/Disability	$		Social Security/Disability	$	
Unemployment/Work comp	$	Date of Unemployment	Unemployment/Work comp	$	Date of Unemployment
Alimony/Child Support	$		Alimony/Child Support Received	$	
Annuities/Dividends/Interest	$		Annuities/Dividends/Interest	$	
Pension	$		Pension	$	
Income From Other Sources	$		Income From Other Sources	$	
TOTAL INCOME FOR PAST 12 MONTHS	$$		**TOTAL INCOME FOR PAST 12 MONTHS**	$$	

If applicant has no income, he/she is required to provide a dated and signed statement from the person(s) who provides their financial support.

Assets:

Checking $_____ Savings $_____ 401K $_____ CDs $_____ IRA $_____ Mutual Funds/Stocks/Bonds $_____

REQUIRED DATA: The Federal Government asks us to collect the following information – thank you in advance for complying.

Please indicate your educational level: _____

Please check if you are a Veteran: ( ) Yes, I am a veteran

Please check one of the following:
( ) Not Homeless ( ) Homeless
( ) Migrant Worker ( ) Other _____

Please check a race and ethnicity:
Race: ( ) Black/African American ( ) White ( ) Asian
( ) Native Hawaiian ( ) Other Pacific Islander ( ) American India/Alaska Native
( ) Other ( ) Refuse to Answer ( ) _____

Ethnicity: ( ) Hispanic / Latino ( ) Not Hispanic ( ) Refuse to Answer

REQUIRED DATA: Public Housing Information

Are you currently living in public housing? ( ) Yes ( ) No

If yes, please check the type of public housing dwelling you live in:

( ) Duplex ( ) High Rise ( ) Low Rise
( ) Single Dwelling (Section 8)

I understand this information will be used only for determination of financial responsibility for my charges at SIU Center for Family Medicine and will be kept confidential. My signature authorizes SIU Center for Family Medicine to verify any information furnished on this form.

To the best of my knowledge, the information provided above is true and correct.

Patient/Signature (if adult): _____ Date: _____

Responsible party signature: _____ Date: _____

Signature of person completing form, if different from patient: _____

PLEASE RETURN THIS COMPLETED APPLICATION AND ALL REQUESTED DOCUMENTATION WITHIN 15 DAYS.
IF THE APPROPRIATE DOCUMENTATION IS NOT ATTACHED, YOUR APPLICATION WILL BE RETURNED TO YOU FOR COMPLETION.

SIU Center for Family Medicine
DISPOSITION, RECOMMENDATION AND APPROVAL

For Office Use Only

Pt Name: _____

_____

MRN#: _____

To be completed by office staff only:

Application Received by: _____
Signature of Financial Counselor

Application Received Date: _____ **Recommendation Date:**_____

Disposition of Application and Recommendation:

Per cent of FPD: _____ **Level:**_____

RECOMMENDED BEST OPTION

( ) Qualifies for Medicaid **( ) Qualifies for Medicare**

( ) Refuses to apply for Medicaid

FQHC Level _____ (reference chart below)

2018 ANNUAL FEDERAL POVERTY LEVEL (FPL) GUIDELINES

FAMILY SIZE -- Members in Household	PERCENT OF FPL					
	2018 FPL	100% or Less FQHC Level 0	101%-138% FQHC Level 1	139%-150% FQHC Level 2	151%-175% FQHC Level 3	176%-200% FQHC Level 4
Annual income displayed is highest possible in each category in order to qualify						
1	$12,140	$12,140	$16,753	$18,210	$21,245	$24,280
2	$16,460	$16,460	$22,715	$24,690	$28,805	$32,920
3	$20,780	$20,780	$28,676	$31,170	$36,365	$41,560
4	$25,100	$25,100	$34,638	$37,650	$43,925	$50,200
5	$29,420	$29,420	$40,600	$44,130	$51,485	$58,840
6	$33,740	$33,740	$46,561	$50,610	$59,045	$67,480
7	$38,060	$38,060	$52,523	$57,090	$66,605	$76,120
8	$42,380	$42,380	$58,484	$63,570	$74,165	$84,760
Each add'l family member > 8	$4,320	$4,320	$5,962	$6,480	$7,560	$8,640

Sliding Fee Scale		Nominal Charge	Level 1	Level 2	Level 3	Level 4
MEDICAL/BEHAVIORAL		$5	$10	$15	$20	$25
DENTAL		$25	20% of charges	40% of charges	60% of charges	80% of charges

(To determine eligibility on applications received on or after March 5, 2018).

If between applying during State Exchange Sign-up Period:

( ) Above 138% of FPL but under or at 200% FPL – Qualifies for State Exchange with Subsidy

( ) Above 200% FPL – Qualifies for State Exchange but no subsidy

FOR REFERENCE ONLY – Patient Assistance Discount Schedule - Adjusted Gross Income (Before IRA/KEOUGH/SEP Deductions)

Recommended by: _____ Date_____

Reviewed and Approved by: _____ Date_____