PATIENT INFORMATION

Last Name	First Name First Name Used	Middle name, suffix
Previous Name (last, first)	Legal Sex ( )Male ( )Female	Date of Birth / /
Social Security Number	Address	City / State/ Zip Code
Mother's maiden name:________________________________ Patient Phone Home: ( ) _______ - _________ Cell: ( ) _______ - _________ Consent to text __Yes __No Work: ( ) _____ - _______	Email:________________________ ______________________________ Access to Patient Portal: [ ] Yes [ ] No Contact Preference Home ___ Work ___ Cell ____ Mail ____ Portal _____	Pharmacy: __________________________ Address___________________ __________________________ Phone:_____-______-________

Language Spoken (mark all that apply)
[ ] English
[ ] Spanish
[ ] Other_______________________
[ ] Declined to Disclose

Interpreter Status [ ] Yes [ ] No

Race
[ ] Asian
[ ] American Indian
[ ] Black\African-American
[ ] Native-Hawaiian
[ ] More than one race
[ ] White
[ ] Other Pacific Islander
[ ] Other _____________
[ ] Declined to Disclose

Ethnicity
[ ] Hispanic or Latino
[ ] Not Hispanic or Latino
[ ] Declined to disclose

Marital Status
[ ] Unknown
[ ] Married
[ ] Single
[ ] Divorced
[ ] Separated
[ ] Widowed
[ ] Partner

Sexual Orientation
____ Lesbian, gay or homosexual
____Straight or heterosexual
____Bisexual
____ Something else, please describe
____ Don't know
____ Choose not to disclose

Agricultural Worker
__yes __no __patient declined

Migrant\Seasonal Status
[ ] Migrant *(A person\dependent whose principle employment has been in agriculture within the last 24 months and has had to establish a temporary home for the purpose of such employment)*
[ ] Seasonal *(A person\dependent whose principle employment has been in agriculture on a seasonal basis and has not had to establish a temporary home for the purpose of such employment)*

Homeless Status __yes __no
[ ] Doubling up
[ ] Homeless Shelter
[ ] Street
[ ] Transitional [ ] Other
[ ] Unknown
[ ] Patient declined

Veteran Status
[ ] YES
[ ] NO
[ ] Patient Declined

Housing Status
[ ] Public Housing
[ ] Not in Public Housing
[ ] Patient Declined

How did you hear about us?
[ ] Advertising
[ ] Primary Care Physician
[ ] Specialist Physician
[ ] Word of Mouth
[ ] Patient in the Practice
[ ] Hospital
[ ] Insurance Company
[ ] Existing Patient
[ ] Other

Pronouns:
__he/him __she/her __they/them

Assigned sex at birth:
__Male
__Female
__Choose not to disclose
__Unknown

Home Bound __Yes __ No

***Gender Identity*:**
___ Identify as a Male
_ __ Transgender Male/Female-to-Male (FTM)
___ Gender non-conforming (neither exclusively male or female)
___ Additional gender category/other/please specify
___ Identify as a Female
___ Transgender Female/Male-to-Female (MTF)
___ Choose not to Disclose

Patient Name: **Date of Birth:**

EMPLOYER INFORMATION

Patient's Employer______________________________

Address ______________________________

City ____________________**State** ____________________**Zip**____________________

Phone Number______________________________

Occupation:______________________________

Employment Status:____ **Full Time** ____ **Part Time** ____**Retired** ____**Student** ____ **Other**

Guardian

Last name:______________________________

First name:______________________________

Middle name, suffix:______________________________

Emergency Contact Name ______________________________

Emergency Contact Number
(   ) ______ **-** ____________

Relationship to Patient ______________________________

Next of Kin

Name:______________________________

Relationship______________________________
Home phone______________________________

Mobile phone______________________________

INCOME INFORMATION

State your household income in one of the following categories listed below

Weekly ______________ **Monthly** ______________ **Yearly/Annual** ______________

[ ] Choose not to provide household income **Signature** ______________________ **Date**______________

Income Information – required by federal government

How many family members live in your home? ______________________________

Please tell us about your family income. Find your family size in the far-left column, then go across that same line and circle your annual household income.

Family Size	Level A	Level B1	Level B2	Level B3	Level B4	Level C
1	$0 to $12,490	$12,490.01 to $15,613.00	$15,613.01 to $18,735.00	$18,735.01 to $21,858.00	$21,858.01 to $24,980.00	$24,980.01 and over
2	$0 to $16,910	$16,910.01 to $21,138.00	$21,138.01 to $25,365.00	$25,365.01 to $29,593.00	$29,593.01 to $33,820.00	$33,820.01 and over
3	$0 to $21,330	$21,330.01 to $26.663.00	$26,663.01 to $31,995.00	$31,995.01 to $37,328.00	$37,328.01 to $42,660.00	$42,660.01 and over
4	$0 to $25,750	$25,750.01 to $32,188.00	$32,188.01 to $38,625.00	$38,625.01 to $45,063.00	$45,063.01 to $51,500.00	$51,500.01 and over
5	$0 to $30,170	$30,170.01 to $37,713.00	$37,713.01 to $45,255.00	$45,255.01 to $52,798.00	$52,798.01 to $60,340.00	$60,340.01 and over
6	$0 to $34,590	$34,590.01 to $43,238.00	$43,238.01 to $51,885.00	$51,885.01 to $60,533.00	$60,533.01 to $69,180.00	$69,180.01 and over
7	$0 to $39,010	$39,010.01 to $48,763.00	$48,763.01 to $58,515.00	$58,515.01 to $68,268.00	$68,268.01 to $78,020.00	$78,020.01 and over
8	$0 to $43,430	$43,430.01 to $54,288.00	$54,288.01 to $65,145.00	$65,145.01 to $76,003.00	$76,003.01 to $86,860.00	$86,860.01 and over
For a family size greater than 8, for each additional family member, add the following to the upper limit						
9+	$4,420.00	$4,420.01 - $5,525.00	$5,525.01- $6,630.00	$6,630.01 - $7,735.00	$7,735.01 - $8,840.00	$8,840.01 and over

If you circled an income range in column C, we thank you for taking the time to complete this form. Please give this form to the receptionist.

If you circled an income range in column A or B1 or B2 or B3 or B4, you may qualify for discounted medical and dental services.

Internal Use: *Patient Service Representative: if a patients income qualifies for A, B1, B2, B3 or B4, please provide patient with a Slide Fee Application

Patient Name: **Date of Birth**

<table>
<tr><td colspan="3">RESPONSIBLE PARTY INFORMATION</td></tr>
<tr><td colspan="3">Person to be billed, if other than the patient (Guarantor)</td></tr>
<tr><td colspan="3">RELATIONSHIP TO PATIENT [ ] Self (skip to next section) [ ] Spouse [ ] Parent [ ] Other</td></tr>
<tr><td>Last Name</td><td>First Name</td><td>Middle Name</td></tr>
<tr><td>SSN</td><td>Date of Birth</td><td>Gender
[ ] Male [ ] Female</td></tr>
<tr><td>Address (if different from above)</td><td>City
State</td><td>Zip Code</td></tr>
<tr><td>Home Phone
( )</td><td>Cell Phone
( )</td><td>Work Phone
( )</td></tr>
<tr><td>Employer</td><td>Employer Address</td><td>City, State, Zip</td></tr>
<tr><td colspan="3">INSURANCE INFORMATION</td></tr>
<tr><td colspan="3">PLEASE PRESENT ALL ACTIVE INSURANCE INFORMATION & A COPY OF INSURANCE CARDS</td></tr>
<tr><td colspan="3">PRIMARY INSURANCE
[ ] No Insurance [ ]Medicaid/Illinois/MCO [ ] Medicare [ ] Other (Employer\Private\Commercial)</td></tr>
<tr><td colspan="3">PATIENTS RELATIONSHIP TO POLICY HOLDER
[ ] Self [ ] Spouse [ ] Child [ ] Other ________________</td></tr>
<tr><td>Plan Name</td><td>Policy Number</td><td>Group Number</td></tr>
<tr><td>Policy Holder Name</td><td>Policy Holder SSN</td><td>Policy Holder Date of Birth</td></tr>
<tr><td colspan="2">Effective Date (if known)</td><td>Co-Pay Amount $</td></tr>
<tr><td>Employer</td><td>Employer Address</td><td>Employer Phone
( ) _______ - ________</td></tr>
<tr><td colspan="3">SECONDARY INSURANCE
[ ]None-skip to next section [ ]Medicaid\Illinois [ ] Medicare [ ] Other (Employer\Private\Commercial)</td></tr>
<tr><td colspan="3">PATIENTS RELATIONSHIP TO POLICY HOLDER
[ ] Self [ ] Spouse [ ] Child [ ] Other ________________</td></tr>
<tr><td>Plan Name</td><td>Policy Number</td><td>Group Number</td></tr>
<tr><td>Policy Holder Name</td><td>Policy Holder SSN</td><td>Policy Holder Date of Birth</td></tr>
<tr><td>Employer</td><td>Employer Address</td><td>Employer Phone
( ) ______ - _________</td></tr>
</table>

___**(please initial)** I hereby authorize the release of my medical information necessary to process claims for the services rendered by Rural Health, Inc. and/or the release of medical information necessary for the application of insurance coverage. A copy of this release will be as valid as the original. I further authorize payment of such services rendered to be made directly to Rural Health, Inc. I understand that I am responsible for any amount not covered by insurance.
___ **(please initial)** I have received a copy of the Rural Health, Inc. "Notice of Privacy Practices" and "No Show Policy".

___**(please initial)** I hereby voluntarily consent treatment, tests, and services I permit Rural Health, Inc. and its employees and others involved in my care to treat me in ways they judge to be beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment. I understand that I have the right to withdraw my consent for treatment or tests. I consent to examinations, diagnostic tests, blood tests (including blood tests for any communicable diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), medications, nursing care, and other services or treatment rendered by my provider or other Rural Health, Inc. personnel under the orders or direction of this provider.

____ ________________________
Patient or Guardian Signature **(please sign)** Date

____ ________________________
RHI Personnel Signature Date

Patient Name: **Date of Birth**

PATIENT FINANCIAL & INSURANCE AGREEMENT

PLEASE READ THOROUGHLY AND SIGN BELOW

In consideration of receiving services from Rural Health, Inc, you agree:

1. All services are provided to you with the understanding that you are responsible for the charges regardless of your insurance coverage. If you would like to know the charge of a service, please inquire prior to treatment. Please be aware that not all services are a covered benefit with different insurance companies. You are responsible for knowing what services are or are not covered. **KNOW YOUR BENEFITS.**

2. At check-in, we will collect your co-pay, deductible, and payment for uncovered services as well as the patient's portion as determined by insurance or sliding fee scale. We accept cash, check, and credit card of Master Card, Visa, and Discover.

3. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. **It is the patient's responsibility to inform our office immediately of insurance coverage or insurance company changes**.

4. You are responsible for knowing if a referral is required. Make sure you know what providers are in your plan, what facilities are covered and what ancillary services you must use. (Such as laboratory, hospitals, etc.) If we can be of assistance, please let us know.

5. We will bill your insurance company as a courtesy, but you are still ultimately responsible for payment of all services you receive. If your insurance company does not respond within 30 days we will follow up with an inquiry on your behalf. If, however, your insurance does not respond within 60 days of claim submission, a statement will be sent to you. You should call your insurance company to question why the claim is not paid. Our office will assist you only after you have contacted your insurance company.

6. If your medical claim has not been paid and your insurance company has not resolved your dispute, you may register a complaint with the Illinois Department of Commerce and Insurance. Our office will do everything we can to assist you; however, you must understand you cannot delay payment while you are awaiting the outcome of your complaint.

7. Any unpaid charges over 90 days old will be sent to an outside collection agency with an additional agency fee. **You are responsible for any collection fees, legal fees, or court costs incurred in the collection process**. This agency will report your failure to pay to the THREE (3) national credit reporting agencies.

8. Returned checks are subject to a $25.00 return check fee.

We do understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems so that we can assist you in the management of your account.

I authorize the Rural Health Inc., to examine, evaluate, and treat me, and/or my child, or ward. I authorize the RHI to release any\all clinical information necessary in order to submit my insurance claims to my insurance companies. I also request that my insurance companies pay benefits directly to the RHI for services rendered. I understand that the RHI will refund any overpayments on my account, in a timely manner.

Your signature below forms a binding agreement between the RHI (the provider of service) and the Patient who is receiving services or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of any charges

______________________________**Print Name of Patient (please print your name)**

______________________________**Patient or Guardian Signature (please sign your name)**

______________________________**Date**

______________________________**RHI Staff Signature**

______________________________**Date**