Chart#

Date

SAMUEL U. RODGERS
HEALTH CENTER

PATIENT DEMOGRAPHIC INFORMATION

This form is to be completed for every patient and placed in Medical Records Chart

O Samuel U. Rodgers Health Center
Downtown Campus

O Samuel U. Rodgers Health Center
Clay County Family Medicine & Dental

O Samuel U. Rodgers Health Center
Lafayette Family Medicine, Dental & WIC Services

O Samuel U. Rodgers Health Center
Cabot Westside Medical and Dental

O Samuel U. Rodgers Health Center
J.A. Rogers Family Dental

Please print:

Name _____ Date of Birth _____ M / F Gender _____

Address _____ Apt # _____ City _____ State/Zip _____

Home Phone _____ Cell Phone _____ Email _____

MARITAL STATUS

O Married O Single O Separated O Divorced

RACE

O American Indian/Alaskan O Asian O Black/African-American O Hispanic/Latino Other O Native Hawaiian O White
O Hispanic/Latino Black O Hispanic/Latino White O Pacific Islander O Refuse to Report O More than One Race

United States Veteran: O Yes O No

INSURANCE INFORMATION

Insurance: O Yes O No Medicaid/Medicare # _____

Private Insurance Name _____ Policy # _____ Group # _____

EMERGENCY CONTACT

Name _____ Relationship _____ Date of Birth _____

Email _____ Cell Phone _____

Preferred method of contact: O email O text O cell phone

TOTAL HOUSEHOLD INCOME INFORMATION

Total Household Size _____ $ Total Household Income before Deductions _____

O Hourly O Weekly O Bi-weekly O Monthly O Semi-Monthly Hours Worked Weekly_____

Parent/Legal Guardian _____ Relationship to patient _____

Phone (if different from patient) _____ Email _____

Preferred method of contact: O email O text O cell phone

PATIENT/LEGAL GUARDIAN

Print Name _____ Signature _____

June 2, 2015

SAMUEL U. RODGERS
HEALTH CENTER

PARENT CONSENT

Date

To Whom It May Concern:

I _____ (mother/father) give permission for _____ (_____) to bring my child _____ to his/her doctor or dentist appointment and to authorize by signature for any shots, treatments, labs, physicals, sick visits, x-rays or dental services if needed. You can contact me at _____.

_____
Parent Name (Printed)

_____ _____
Parent Signature Date

May 12, 2015

SAMUEL U. RODGERS
HEALTH CENTER

GENERAL CONSENT FORM

The undersigned patient and/or responsible person having registered at Samuel U. Rodgers Health Center for the purposes of obtaining health services, do hereby, voluntarily consent such diagnostic and treatment services, as might be provided by or at the direction of a physician, dentist, or other health care professional or other qualified member of the staff of the Samuel U. Rodgers Health Center to me according to his/her judgment.

I recognize that I have the right to refuse any specific diagnostic or treatment service without jeopardizing my right to receive health services at the Health Center.

I recognize that I will be asked to sign a specific consent for surgical and other special procedures including general and/or extensive local anesthesia. I am aware that health services are not based on an exact science and I acknowledge that no guarantees have been made to me as to the results of any treatment services.

I hereby authorize Samuel U. Rodgers Health Center to furnish such information from my medical record pertaining to any and all treatment as requested by either health insurance plans or companies if applicable to my case. I give my consent to release my information to Pharmaceutical Companies for auditing purposes in the Bulk Replacement Patient Assistance Programs.

I hereby authorize payment of health insurance benefits recorded on the registration form to be paid directly to Samuel U. Rodgers Health Center for services provided.

I understand that the charges for which I am responsible will reflect the balance due after credit for all appropriate discounts and all collections received by Samuel U. Rodgers Health Center from health insurance benefits.

I agree to pay these charges on the day that the services are provided or within 10 days of receipt of the statement or by some other payment arrangement agreed to by the billing/collections department at Samuel U. Rodgers Health Center.

I hereby certify that I have been offered a copy of the Samuel U. Rodgers Health Center's Notice of Privacy Practices.

I hereby certify that I have been offered a copy of Samuel U. Rodgers Health Center's Appointment Cancellation Policy. Patients that choose not to keep scheduled appointments and who fail to keep their appointment three (3) times within a six (6) month period will only be seen on a same-day basis in the future. Canceling with short notice (less than 24 hours), showing up late, or not showing up at all is very disruptive for our schedule and unfair to our other patients who value prompt treatment.

I hereby certify that I have not knowingly withheld any information or income or other financial resources and the amounts I have disclosed are true and correct to the best of my knowledge. If I have knowingly provided any false information I may be prohibited from receiving services at Samuel U. Rodgers Health Center in the future. I certify I will contact the facility in the event I have an insurance and/or income change.

This form has been fully explained to me and I certify that I understand its contents.

Signature _____ Date _____

Witness _____ Date _____

I authorize any holder of medical or other information about me to be released to the Social Security Administration and its intermediaries or carriers as information is needed for this or a related Medicare claim. I permit a copy of this authorization to be used in the place of the original and request payment of medical insurance benefits to Samuel U. Rodgers Health Center.

Signature _____ Date _____

Witness _____ Certification Date _____

June 2, 2015

SAMUEL U. RODGERS
HEALTH CENTER

CONSENT TO CARE:

_____ I hereby voluntarily consent to the rendering of such care, including mental health services, diagnostic procedures and medical treatment by SURHC, its medical doctors or its authorized designees, as may, in their professional judgment, be necessary to provide for my medical care.

Legal Guardian/Representative or Minor Child:

I,_____, am the parent or legal guardian of the patient, _____(dob_____/_____/_____), and I hereby voluntarily consent to the rendering of such care, including mental health services, diagnostic procedures and medical treatment, by Samuel U. Rodgers Health Center ("SURHC"), its medical doctors or its authorized designees, as may, in their professional judgment, be necessary to provide for the medical care of the aforementioned minor.

In making medical decisions for the minor, I direct that the SURHC attempt to contact me. However, if medical care becomes essential, I give permission to SURHC to make such decisions regarding such treatment as deemed appropriate by the medical doctor, hospital or their authorized designee. In furtherance of any treatment decisions to be made by SURHC on my behalf for the benefit of such minor, I authorize SURHC to request, obtain, review and inspect any and all information bearing upon his or her health and with respect to such treatment.

I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on the condition of the minor and that I am responsible for all reasonable charges in connection with the care and treatment rendered during this period.

CONSENT FOR HEALTH INFORMATION EXCHANGE:

Samuel U. Rodger's Health Center ("SURHC") participates in Health Information Exchanges ("HIE"). HIEs give participating health care professionals, facilities, and others involved in your care the ability to view your health information for purposes permitted by the Health Insurance Portability and Accountability Act of 1996 and the implementation regulations thereunder ("HIPAA") and Missouri state law.

Your participation in the HIE is voluntary and your receipt of treatment or payment for treatment will not be conditioned on your consent.

_____ **I GIVE CONSENT for SURHC to make my health information available to HIEs in which SURHC participates so that all health care professionals, facilities, and others involved in my care will have the ability to access my medical records in providing care to me and for other lawful purposes. By giving such consent to SURHC, I also give consent for other health care professionals that participate in the HIEs to make my health information available to the HIEs.**

- I understand such information may include health information that may be considered particularly sensitive to me including: (i) mental health or developmental disability information; (ii) HIV/AIDS information and test results; (iii) substance abuse treatment, evaluations, drug testing or screening;
  (iv) genetic information and test results; (v) head trauma and brain and spinal

cord injuries; (vi) STD and other communicable disease treatment and test results; and (vii) family planning information, including abortions.

- I understand that the health information shared with the HIE includes all of my health records, including but not limited to: (i) illness or injuries; (ii) test results; and (iii) medications I am taking or have taken.
- I understand that my health information may be incorporated into the record of any health care provider accessing it through the HIE and may be used as permitted by law.
- I understand that this consent applies to information generated by SURHC and my other health care providers both prior to the date of this consent and during any subsequent visit while this consent is in effect.
- I may revoke this consent in writing, at any time; by notifying SURHC. I understand however, that any such revocation will not apply to any sharing of my health information that occurred prior to the date the written revocation was received. Upon a revocation of this consent, SURHC may communicate my revocation to the relevant HIEs, using my name and other limited information unrelated to my clinical care, so that the HIEs can make sure that none of my health information (either from SURHC or any of my other health care providers) is made available through the HIE.

_____ **I DO NOT GIVE CONSENT for SURHC (or any of my other health care providers) to make my health information available to HIEs in which SURHC participates.**

- I understand that by not giving consent, health care providers will not have access to any of my health information (from SURHC or my other health care providers) through an HIE - ***even in an emergency situation when electronic access to my health information may help care for me or save my life.***

- I understand that even if I do not give my consent for SURHC to make my health information available to an HIE, SURHC may still notify the HIEs, using my name and other information unrelated to my clinical care or health conditions, of my decision to not give consent so the HIEs can make sure that none of my health information from any of my other health care providers is made available through the HIE.0

_____ _____

Patient Name (Print) Patient Date of Birth (mm/dd/yyyy)

_____ _____

Signature of Patient (or Legal Representative)
years signature of Parent or Guardian

Date Signed If under 18

_____ _____

Legal Representative Name Relationship to Patient

s

You have the right to receive a copy of this consent upon request.

SAMUEL U. RODGERS
HEALTH CENTER

About the

Notice of Privacy Practices

The Health Center is committed to protecting patients' personal health information in compliance with Federal law. The attached Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint, if you believe your privacy rights have been violated.
- The person to contact for further information about our privacy practices.

We are required by law to offer all patients a copy of our Notice of Privacy Practices.

Patient Acknowledgment of Receipt

I, _____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

_____
Patient's Signature Date

_____
Signature of Parent or Patient's Representative Date

_____
Description of Legal Authority to Act on Behalf of Patient Date

_____
Interpreter Signature Date

SAMUEL U. RODGERS
HEALTH CENTER

SAMUEL U. RODGERS HEALTH CENTER
PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

We welcome you as a patient to Samuel U. Rodgers Health Center. It is the policy of the Health Center to inform and notify patients of their rights and responsibilities regarding our health care services.

With your cooperation, we want to help you enjoy the best health possible.

Patient Rights: (Our Responsibility to You)

1. You have the right to refuse treatment.
2. You have the right to be fully informed of all rules and regulations governing center activities.
3. You have the right to be informed of all available services at the Health Center.
4. You have the right to an explanation about charges for services including third-party payment.
5. You are entitled to information concerning your medical condition and plan for treatment.
6. You may refuse to participate in any experimental research.
7. You have the right to submit complaints and recommend policy changes to center staff and governing body.
8. You will be informed of the procedure to follow in case of emergency when the Health Center is closed.
9. Your records are confidential. You have the right to refuse the release of your medical information except as required by third-party payment contracts.
10. At all times you are to be treated with respect, consideration and dignity, including privacy in treatment and personal needs.

Patient Responsibilities: (Your Responsibilities as a Patient)

1. You are responsible for keeping your appointments, or notifying the Health Center in advance when unable to do so.
2. You are obligated to give truthful information.
3. You are expected to abide by all rules and regulations with regard to patient conduct to responsibilities.
4. You are responsible for taking medications and treatments as prescribed by your doctor.
5. You are responsible for paying fees and co-pays according to insurance and sliding fee scales.

Confirmation of Receiving Patient Bill of Rights

I have been given the opportunity to have a copy of the Samuel U. Rodgers Health Centers' Patient Bill of Rights. After reading this document, I have had a chance to ask questions and believe I understand what the Patient Bill of Rights means, what I might expect from this health care facility and what is expected of me and my family members as registered patients of the Health Center.

Signature:_____ Date:_____

Interviewers Initials:_____ Date:_____

Interpreter's Signature:_____ Date:_____

SAMUEL U. RODGERS
HEALTH CENTER

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- The person to contact for further information about our privacy practices.

We are required by law to offer all patients a copy of our Notice of Privacy Practices.

Patient Acknowledgment of Receipt

I, _____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

_____

Patient's Signature **Date**

_____

Signature of Parent or Patient's Representative (if applicable) **Date**

_____

Description of Legal Authority to Act on Behalf of Patient

_____

Interpreter signature **Date**

Revised 6/2010

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