Vermillion-Parke Community Health Center

777 S. Main Street, Suite 100 Clinton, IN 47842
Phone: (765) 828-1003 Fax: (765) 828-1030

114 N. Division Street, Cayuga, IN 47928
Phone: (765) 492-9042 Fax: (765) 492-9048

PATIENT INFORMATION

Patient Account #:_____
(for office use only)

Today's Date: _____

Patient Name: _____ Sex: ☐ M ☐ F
(please check)

Address: _____ Apt #:_____

City: _____ State: _____ Zip: _____ County _____

SS#: _____ Date of Birth: _____

Home Phone: _____Cell: _____Work: _____

May we Email you? ☐ Yes ☐ No If so, e-mail address:_____

☐ **Full-time** ☐ **Part-time** ☐ **Unemployed** ☐ **Self-employed** ☐ **Student**

Patient's Employer: _____

VPCHC is a Federally Qualified Health Center that receives government funding. The funding for *your* health center is based on information you provide and is necessary for us to better serve *you*, our patient. Please complete the following information for reporting purposes. Your answers will also help us to determine if you qualify for our Sliding Fee Scale.

I am (check one): ☐ **Providing the following information for reporting purposes only**

☐ **Applying for Sliding Fee Scale**

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race: ☐ Multi-Race ☐ American Indian/Alaskan ☐ Black/African American
☐ Asian ☐ White/Caucasian ☐ Pacific Islander or Native-Hawaiian

Primary Language at Home: ☐ English ☐ Spanish ***Number of People in Household:*** _____

Do you need an Interpreter? ☐ Yes ☐ No ***Ethnicity:*** Hispanic/Latino ☐ Yes ☐ No

Military Service: ☐ Yes ☐ No ***Homeless:*** ☐ Yes ☐ No ***Migrant Worker:*** ☐ Yes ☐ No

Health Insurance: ☐ Yes ☐ No ***Medicare:*** ☐ Yes ☐ No ***Medicaid:*** ☐ Yes ☐ No

Self-declared monthly income: ☐ ***Less than $1467*** ☐ ***Between $1468 - $2201***
☐ ***Between $2202 - $2934*** ☐ ***More than $2935***

Vermillion-Parke Community Health Center

PLEASE CIRCLE ANY AREAS OF INTEREST YOU MAY HAVE

Sliding Fee Scale	Food Stamps	Medicaid	Hoosier Healthwise	Transportation Assistance
Prescription Assistance	Food Assistance	Dental Assistance	Counseling (Family/Individual)	Other Assistance: _____

May we send you information on the above? ☐ Yes ☐ No

List of People in Household	Relationship to Patient	Birth Date
1. Patient	Self	
2.		
3.		
4.		
5.		
6.		

Emergency Contact Information

Name: _____Relationship to patient:_____

Home Phone: _____Cell: _____Work: _____

Referring Physician:_____ Phone:_____

Release of Protected Health Information

I, _____, hereby authorize Vermillion-Parke
(please print your name)
Community Health Center to release/discuss my protected health information with the following people:

Name	Relationship	Phone Number
1.		
2.		
3.		

I understand I have the right to revoke this authorization, in writing, at any time by sending written notice to VPCHC. I understand that if I revoke the authorization, the revocation will not apply to information that has already been released in response to the authorization or to information that VPCHC has used based on this authorization. If I have questions about the use and disclosure of my information, I can contact VPCHC at (765) 828-1003 or (765) 492-9042.

_____ _____

Patient Signature Date Witness Signature (office staff)

Vermillion-Parke Community Health Center

Insured's Information (Person who carries the insurance) ☐ check box if the information on page 1 is the same.

Name: _____

Address: _____ Apt #:_____

City: _____ State: _____ Zip: _____

SS#: _____ Date of Birth: _____

Home Phone: _____Cell: _____Work: _____

Insured's Employer: _____

Guarantor Information (Person Responsible for bill or parent of child)

Name: _____

Address: _____ Apt #:_____

City: _____ State: _____ Zip: _____

SS#: _____ Date of Birth: _____

Home Phone: _____Cell: _____Work: _____

Insured's Employer: _____

Please Note: We will file insurance as a courtesy to our patients. In order to file your insurance for you, we will need the proper insurance information. Please fill out the following information in order for us to file your insurance. If we are not able to collect from your insurance, you will be responsible for any services that are rendered.

Primary Insurance: _____ Phone:_____

Address:_____ City:_____ Zip:_____

Policy Number: _____ Group Number: _____

Policy Holder (Name on card): _____

Date of Birth: _____ Relationship to patient: _____

Secondary Insurance: _____ Phone: _____

Address:_____ City:_____ Zip:_____

Policy Number: _____ Group Number: _____

Policy Holder (Name on card): _____

Date of Birth: _____ Relationship to patient: _____

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AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

Date of Request: _____ **Purpose of Disclosure:**

_____ Patient Name _____ Street Address _____ City/State/Zip _____ Phone Date of Birth	_____ Referring Physician to Physician _____Continuing Care/Second Opinion _____Personal _____Attorney _____ Employer _____Disability _____Insurance _____Other

Physician where medical records will be obtained: **Information Requested:**

_____ Name _____ Street Address _____ City/State/Zip	_____Recent/Pertinent Laboratory Results _____Radiology Reports _____EKG report/tracing _____Consultant Letters _____Any Pertinent Medical History (abnormal results, etc.) _____All the above

This authorization shall be in force and effect for 60 days at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing at any time by sending such written notification to the Vermillion-Parke Community Health Center. I understand that a revocation is not effective to the extent that the Vermillion-Parke Community Health Center has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this information may be subject to re-disclosure by the recipient and may be no longer protected by federal or state law.

Vermillion-Parke Community Health Center will not condition my treatment, payment, enrollment in a health plan or eligibility benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.
- Receive a signed copy of this authorization.

I do not want the following information released/obtained:

_____ Alcohol
_____ Depression
_____ Hepatitis
_____ Drugs
_____ Sexually transmitted diseases
_____ HIV/AIDS

_____ _____
Signature of Patient or Personal Representative Date

PHQ-9 — Nine Symptom Checklist

Patient Name _____ **Date** _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

   a. Little interest or pleasure in doing things
   Not at all **Several days** **More than half the days** **Nearly every day**

   b. Feeling down, depressed, or hopeless
   Not at all **Several days** **More than half the days** **Nearly every day**

   c. Trouble falling asleep, staying asleep, or sleeping too much
   Not at all **Several days** **More than half the days** **Nearly every day**

   d. Feeling tired or having little energy
   Not at all **Several days** **More than half the days** **Nearly every day**

   e. Poor appetite or overeating
   Not at all **Several days** **More than half the days** **Nearly every day**

   f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down
   Not at all **Several days** **More than half the days** **Nearly every day**

   g. Trouble concentrating on things such as reading the newspaper or watching television
   Not at all **Several days** **More than half the days** **Nearly every day**

   h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual
   Not at all **Several days** **More than half the days** **Nearly every day**

   i. Thinking that you would be better off dead or that you want to hurt yourself in some way
   Not at all **Several days** **More than half the days** **Nearly every day**

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

   Not Difficult at All **Somewhat Difficult** **Very Difficult** **Extremely Difficult**

Vermillion-Parke Community Health Center

Patients' Bill of Rights and Responsibilities

Vermillion Parke Community Health Center ("VPCHC") is committed to providing high quality care that is fair, responsive, and accountable to the needs of our patients and their families. We are committed to providing our patients and their families with a means to not only receive appropriate health care and related services, but also to address any concerns they may have regarding such services.

EVERY PATIENT HAS A RIGHT TO:

1. Receive high quality care based on professional standards of practice, regardless of his or her (or his or her family's) ability to pay for such services.

2. Obtain services without discrimination on the basis of race, ethnicity, national origin, sex, age, religion, physical or mental disability, sexual orientation or preference, marital status, socio-economic status or diagnosis/condition.

3. Be treated with courtesy, consideration and respect by all VPCHC staff, at all times and under all circumstances, and in a manner that respects his or her dignity and privacy.

4. Receive a complete, accurate and easily understood, explanation of any diagnosis, treatment, prognosis, and/or planned course of treatment, alternatives (including no treatment), and associated risks/benefits.

5. Receive information regarding the availability of support services, including translation, transportation and education services.

6. Receive an itemized copy of the bill for his or her services, an explanation of charges, and description of the services that will be charged to his/her insurance.

7. Request any additional assistance necessary to understand and/or comply with the VPCHC's administrative procedures and rules.

8. File a grievance or complaint about the VPCHC or its staff without fear of discrimination or retaliation and have it resolved in a fair, efficient and timely manner. To file a complaint write out your concerns and deliver them to :

Elizabeth Burrows, CEO
Vermillion-Parke Community Health Center, Inc.
777 South Main Street
Clinton, IN 47842

EVERY PATIENT IS RESPONSIBLE FOR :

1. Providing accurate personal, financial, insurance, and medical information (including all current treatments and medications) prior to receiving services from the VPCHC and its health care providers.

2. Following all administrative and operational rules and procedures of VPCHC.

3. Supervising his or her children while in the VPCHC facility(s).

4. Refraining from abusive, harmful, threatening, or rude conduct towards other patients and/or the VPCHC staff.

5. Not carrying any type of weapon or explosives into the VPCHC facility(s).

6. Keeping all scheduled appointments and arriving on time. Patients that arrive more than 15 minutes late for an appointment may be required to reschedule their appointment.

7. Notifying the VPCHC no later than 24 hours (or as soon as possible within 24 hours) prior to the time of an appointment that he/she cannot keep the appointment as scheduled. Failure to follow this policy may result in being charged for the visit and/or being placed on a waiting list for the next visit.

8. Participating in and following the treatment plan recommended by his or her health care providers, to the extent he or she is able, and working with providers to achieve desired health outcomes.

9. Informing his or her health care providers of any changes or reactions to medication and/or treatment.

10. When a fee is charged, making a good faith effort to meet financial obligations, including promptly paying for services provided.

11. Advising the VPCHC of any concerns, problems, or dissatisfaction with the services provided or the manner in which (or by whom) they are furnished.

12. Not bringing pets into the facility.

_____ _____

Signed Printed Name

Last Name First Name M.I.

VERMILLION PARKE COMMUNITY HEALTH CENTER

Acknowledgment of Receipt of Notice of Privacy Practice

By my signature below, I acknowledge that I have received the Notice of Privacy Practice.

Signature Date

Relationship to patient (if not signed by patient) Staff initials

VP-5591 12-07

NOTICE OF PRIVACY PRACTICES

Effective Date of this Notice: April 14, 2003

Vermillion Parke Community Health Center
777 S. Main Street, Suite 100
Clinton, IN 47842

Our Pledge Regarding Medical Information
We understand that medical information about you and your health is personal, and we are committed to protecting your privacy. We create a record of the care and services you receive at this facility. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all records of your care generated by this facility whether in paper of electronic form.

How We May Use and Disclose Your Medical Information

The following categories describe different ways that we use and disclose medical information. Information may be disclosed in writing, orally or electronically. Not every use or disclosure in each category will be listed; however, all of the ways we are permitted to use and disclose information will fall within one of the categories.

1. For Treatment:
   We will use your medical information to provide you with quality treatment or services. Your information may be accessed by various people who are involved in your care (example: doctors, nurses, technicians, students, clerks, laboratory personnel, ect…). Different departments may share medical information about you in order to coordinate the different things you need. For example: a doctor will share your medical information with another physician if you are referred for specialized care. We may also share your medical information with a family member or friend who will assist with your care outside this facility.
2. For Payment:
   We will use and disclose your medical information so that we can bill for the services you received and collect payment. For example, we may share information with your insurance company to obtain prior approval for treatment when applicable, or to bill and receive reimbursement for treatment you received.
3. For Operations:
   We may use and disclose your medical information as necessary to run our facility and provide our patients with quality care. Examples of uses and disclosures include, but are not limited to, the following:
   - To send you appointment reminders;
   - To inform you about or recommend possible treatment options or alternatives that may be of interest to you;
   - To provide you with information about health-related benefits and services that may be of interest to you;
   - To review our services, evaluate our performance, and decide what additional services we should offer;
   - To volunteers who assist our patients;
   - For research purposes under certain circumstances;
   - To outside organizations called our Business Associates who perform a task on our behalf, such as an outside billing agency;
   - To doctors, nurses, students and other personnel for review and learning purposes.
4. As required by Law:
   - We may use and disclose our medical information as required in the following situations:
   - To prevent a serious threat to your health and safety or the health and safety of another person or the public;
   - To report public health activities or risks, such as infectious disease or abuse cases;
   - To report births or deaths;
   - For health oversight activities, which could include audits, investigations, inspections and licensure;

- To a court or in response to an administrative order, subpoena, discovery request or other process if you are involved in a lawsuit or dispute;
- To law enforcement officials in response to a criminal investigation, warrant, ect.;
- To federal officials for intelligence and other national security activities authorized by law;
- To coroners, medical examiners or funeral directors;
- To worker compensation programs when applicable;
- To organ donation or procurement programs when applicable;
- To military command authorities, as applicable, if you are a member of the Armed Forces.

5. Other Uses of Medical Information:
   Other uses and disclosures of medical information not covered by this Notice or law will be made only with your written permission. If you provide us permission to use or disclose your medical information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures we may have already made while we had your permission, and that we are required by law to retain our records of the care we provided to you.

Your Rights Regarding Your Medical Information

1. Right to Inspect and Copy:
   As a patient of ours, you have the opportunity to review your information or receive copies of your records. This includes medical and billing records, but does not include psychotherapy notes. If you request a copy of your records, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. To review or request a copy of your record, contact the medical records department at (765) 828-1003 for the Vermillion-Parke Community Health Center.
2. Right to Amend:
   If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, contact Elizabeth Burrows, CEO, at (765) 828-1003. They will give you the appropriate form to complete which must include the reason for your request. We will deny your request for an amendment if it is not in writing or does not include a reason for the request. In addition, we may deny your request if it is deemed that our information is accurate and complete.
3. Right to Accounting of Disclosures:
   You have the right to request an accounting of disclosures, that is, a list of the persons to whom we sent some or all of your medical information. This accounting can begin no earlier than our HIPAA Privacy Standards compliance effective date of April 14, 2003, and can include a maximum of six-year period. Contact Elizabeth Burrows, CEO at (765) 828-1003 to begin this process. We will charge you for the cost of providing more than one accounting during a 12-month period. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any charges are incurred.
4. Right to Request Restrictions:
   You have the right to request a restriction or limitation of the medical information we use or disclose about you for treatment, payment or other health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in our care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about this visit. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, contact Elizabeth Burrows, CEO at (765) 828-1003. You will be given the appropriate form to complete your request which must include:
   - What information you want to limit;
   - Whether you want to limit our use, disclosure, or both; and
   - To whom you want the limits to apply, for example, disclosures to your spouse
5. Right to Request Confidential Communications:
   You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. You may request confidential communication during your registration process. Any request made after you have been registered, should be made to Elizabeth Burrows, CEO at (765) 828-1003.