MEDICAL/BEHAVIORAL HEALTH HISTORY – 1 OF 2

Updated 2/4/2022

Maple Street Clinic
109 E. Maple, Gillespie, IL 62033
217-839-1526 ~ Medical/Behavioral
217-839-1538 ~ FAX
217-839-4110 ~ Dental

Macoupin County Public Health Department

Morgan Street Clinic
1115 Morgan St., Carlinville, IL 62626
Medical/Behavioral ~ 217-854-3692
FAX ~ 217-930-2293
Dental ~ 217-854-6823

Columbian Blvd. Dental Clinic ~ 125 W. Columbian Blvd. South ~ Litchfield, IL 62056 ~ 217-250-2360 (p) ~ 217-250-2365 (fax)
St. Francis Way Clinic ~ 805 St. Francis Way ~ Litchfield, IL 62056 ~ 217-250-2380 (p) ~ 217-250-2385 (fax)
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Last Name:_____ **First Name**:_____ **MI**: _____
(please print)

Today's Date: _____ **Birth Date**: _____

Gender Identity: Female / Male / Female to Male / Male to Female / Genderqueer / Choose not to disclose /
Other:_____

Sexual Orientation: Straight-heterosexual / Lesbian, gay, or homosexual / Bisexual / Don't know / Choose not to disclose / Something else:
_____

If the patient is a minor, please provide the parent's/guardian's name: _____

MEDICAL HISTORY

Please list all the medications you are currently taking including dose and directions:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Y	N	High Blood Pressure	Y	N	Herpes/Fever Blisters	Y	N	Epilepsy/Seizures
Y	N	Low Blood Pressure	Y	N	HIV+/AIDS	Y	N	Migraines/Headaches
Y	N	Pacemaker	Y	N	Hepatitis	Y	N	Fainting/Dizzy spells
Y	N	Mitral Valve Prolapse	Y	N	Liver Disease	Y	N	Sinus Problems
Y	N	Heart Attack	Y	N	Kidney Problems	Y	N	Psychiatric Conditions
Y	N	Heart Surgery	Y	N	Diabetes	Y	N	Difficulty Breathing
Y	N	Heart Murmur	Y	N	Ulcers/Colitis	Y	N	Coronary Artery Disease
Y	N	Congenital Heart Defect	Y	N	Arthritis	Y	N	Asthma
Y	N	Anemia	Y	N	Artificial Joints/Valves	Y	N	Emphysema
Y	N	Bleeding Problems	Y	N	Cancer	Y	N	Stroke
Y	N	Bruise Easily	Y	N	Chemotherapy	Other Conditions not listed:		
Y	N	Sickle Cell Anemia	Y	N	Radiation Treatment	_____		
Y	N	Hemophilia	Y	N	Hospitalized for any reason	_____		

Y N **Tobacco use?** If yes, how many packs a day? _____ How many years? _____

SCREENING TEST HISTORY

Have you had a colonoscopy? Y N If yes, where? _____ Date: _____

Women:

Have you had a PAP smear? Y N If yes, where? _____ Date: _____

Have you had a mammogram? Y N If yes, where? _____ Date: _____

Are you pregnant? Y N If yes, when is your due date? _____

Are you nursing? Y N

ALLERGIES

Are you allergic to any food or medication? Y N

Allergy: _____ Reaction: _____ Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____ Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____ Allergy: _____ Reaction: _____

SURGICAL HISTORY

Surgery: _____ Date: _____ Location: _____ Complications: _____ Reason: _____

Surgery: _____ Date: _____ Location: _____ Complications: _____ Reason: _____

Surgery: _____ Date: _____ Location: _____ Complications: _____ Reason: _____

FAMILY HISTORY

Please provide family history of diagnosis/disease for immediate family only.

Y	N	Diabetes	If yes, relation: _____	Y	N	Cancer Type:_____	If yes, relation: _____
Y	N	Heart Attack	If yes, relation: _____	Y	N	Stroke	If yes, relation: _____
Y	N	Low Blood Pressure	If yes, relation: _____	Y	N	Other: _____	If yes, relation: _____
Y	N	High Blood Pressure	If yes, relation: _____	Y	N	Other: _____	If yes, relation: _____

PATIENT AUTHORIZATION/CONSENT TO TREATMENT

The information I have provided is correct to the best of my knowledge. I assume any risk to myself or my dependent and understand that I will ask if there are any questions regarding diagnosis or treatment. I understand it is my responsibility to inform this office of any changes in my/my dependent's medical status and/or medications being taken. I understand that I will be expected to update the information on this history form on an annual basis.

Patient/Parent's Signature:_____ **Date**: _____

Remainder of page intentionally left blank

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PATIENT INFORMATION:

First Name*:_____ MI:_____ Last Name*:_____ Suffix:_____

***print all names exactly as they appear on your insurance card**

Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____

Gender Identity: ☐ Female ☐ Female to Male ☐ Genderqueer ☐ Other:
☐ Male ☐ Male to Female ☐ Choose not to disclose _____

Sexual Orientation: ☐ Straight - heterosexual ☐ Bisexual ☐ Choose not to disclose
☐ Lesbian, gay, or homosexual ☐ Don't Know
☐ Something else, please describe: _____

Address: _____
(Street Address) (City) (State) (Zip)

Mailing Address (if different): _____
(Street Address) (City) (State) (Zip)

Primary Phone Number: _____ Alternate Phone Number: _____

Email Address: _____ Mother's Maiden Name: _____

How do you prefer to be contacted? ☐ Primary Phone ☐ Alternate Phone ☐ Email ☐ Mailing address

RACE (mark ALL that apply)

☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Declined to specify

☐ More than one race ☐ Native Hawaiian ☐ Other/Pacific Islander ☐ White

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown

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

Are you a student? ☐ Yes ☐ No **Are you a veteran?** ☐ Yes ☐ No

Are you a smoker? ☐ Yes ☐ No **Are you a migrant worker?** ☐ Yes ☐ No

Housing: ☐ Own ☐ Rent ☐ Homeless ☐ Living with friends/family

Do you live in Income-based Public Housing? ☐ Yes ☐ No

How many people live in your family unit? _____

What is your annual household gross income? (check one below)

☐ $0-$10,000 ☐ $10,001-$20,000 ☐ $20,001-$30,000 ☐ $30,001-$40,000 ☐ $40,001-$50,000 ☐ $50,001+

PARENT'S INFORMATION (if patient is a child)

First Name: _____ MI: _____ Last Name: _____ Suffix: _____

Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female

Address: _____
(Street Address) (City) (State) (Zip)

INSURANCE INFORMATION: Check all that apply

☐ MEDICAID ☐ ALL KIDS ☐ MEDICARE ☐ PRIVATE INSURANCE

☐ SELF PAY ☐ SLIDING FEE

Insurance Policy Information:

Name of Policy Holder: _____

Social Security Number of Policy Holder: _____ - _____ - _____ Date of Birth: _____/_____/_____

Name of Medical Insurance: _____

Policy Number: _____ Member Number: _____ Effective Date: _____

Name of Dental Insurance: _____

Policy Number: _____ Member Number: _____ Effective Date: _____

EMERGENCY CONTACT INFORMATION:

Name: _____

Relationship: _____ Phone Number: _____

HOW DID YOU HEAR ABOUT US?

☐ FAMILY MEMBER/FRIEND ☐ SOCIAL MEDIA ☐ DOCTOR ☐ VA ☐ SCHOOL

☐ I AM A CURRENT PATIENT ☐ BROCHURE ☐ OTHER (please specify)_____

All clients have the right to treatment by Macoupin County Public Health Centers without discrimination to age, race, color, religion, sex, sexual orientation or national origin. The above information is true and correct to the best of my knowledge.

I accept full responsibility for my/my child's care and treatment and release the Macoupin County Public Health Centers and staff of any and all liability for any adverse results that may occur due to my refusal to follow the recommended plan of treatment.

I authorize Macoupin County Public Health Centers to provide services to me and to release necessary information to bill, process, and receive payment of medical/dental benefits (private insurance, Medicare, or Medicaid, etc.) for medical and professional services rendered.

Client (or Parent) Signature: _____ **Date:**_____

Relationship to Patient if a minor: _____

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Acknowledgment of Notice of Privacy Practices

My signature below indicates that I have been given an opportunity to read the Notice of Privacy Practices for the **Macoupin County Public Health Department**, and to have any questions answered before signing.

Printed Name: _____ Date: _____

Signature: _____

Patient Name: _____ Patient Date of Birth: _____
(please print)

If signed by someone other than the patient, please indicate relationship to patient:

( ) Parent or guardian of minor patient

( ) Guardian or conservator of an incompetent patient

( ) Beneficiary or personal representative of deceased patient

Consent to Release Information to Designated Family Member of Caregiver

The names listed below are allowed to have information released to them from Macoupin County Public Health Department with the undersigned consent.

_____ _____
Name to receive information and relationship — Type of information **not** to release

_____ _____
Name to receive information and relationship — Type of information **not** to release

_____ _____
Name to receive information and relationship — Type of information **not** to release

This consent remains in effect for one (1) year period and will be updated and signed on a yearly basis or as needed per patient request. This consent may be revoked at any time upon written request.

FOR OFFICE USE ONLY:

Employee Signature: _____ Date: _____
If patient or patient's representative refuses to sign this acknowledgement:

( ) Efforts to obtain: _____

( ) Reason patient refused to sign: _____

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HIPAA Consent to Use/Disclose Health Information

Client Name: _____ Date: _____

This form is an agreement between you and Maple Street Clinic/Morgan Street Clinic/Macoupin County Public Health Clinic Site. When we use the word "you" below, it will mean your child, relative, or other person if you are the parent/guardian of the client named above.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We use this information to decide on what treatment is best for you and to provide treatment to you, to arrange payment for your treatment or for other business or government function as permitted or required by law.

By signing this form, you are agreeing to let us use your information and/or send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent Form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

In the future we may change how we use and share your information and so we may change our Notice of Privacy Practices. If we do change it, we will post it in the waiting room, or you can get a copy from our privacy officer.

If you are concerned about some of your information, you have that right to ask us to not use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations.

After you have signed this consent, you have the right to revoke it by writing a letter telling us you no longer consent and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

I have received and read the HIPAA Notice of Privacy Practices and consent to the use and disclose of my protected healthcare information as specified.

SIGNATURES

Client: _____ **Date:** _____

Parent/Guardian: _____ **Date:** _____

Witness: _____ **Date:** _____

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Payment Acknowledgment Form

(Please sign next to <u>one</u> of the following)

A. I, _____, acknowledge that I have Medicaid, Medicare, or private insurance and **that I will provide a copy of my active insurance information** on the date of my visit. If, for any reason, my insurance company denies payment, I understand that I am liable for all charges incurred. If insurance pays a portion of the charges, I understand the remainder is my responsibility.

B. I, _____, **acknowledge that I have been approved for the Sliding Fee Discount Program or Prompt Pay**. I know my fee per visit and understand that this flat fee is my responsibility to pay along with any additional fees for labs, immunizations, and non-covered services. I also understand that my sliding fee approval is only active until the Federal Poverty Guidelines change, after which, I will need to bring in proof of income and apply again.

C. I, _____, **acknowledge that I have applied for the Zero Income Affidavit**. I know my fee per visit is zero and understand that it is my responsibility to pay any additional fees for certain labs, tests, and non-covered services, or if the zero income affidavit is denied. I also understand that my zero income affidavit is only active for 60 days, after which, I need to apply again or apply for the Sliding Fee Discount Program if I have income.

D. I, _____, **acknowledge that my sliding fee or Prompt Pay expired**. I promise to bring proof of income as described in the Sliding Fee Discount Eligibility Criteria. I understand that if I do not comply with this agreement, I am liable for all charges incurred on each visit from here forward (until sliding fee paperwork and proof are provided).

E. I, _____, **acknowledge that I do not have an active sliding fee, Prompt Pay or Zero Income Affidavit on my account, nor do I want to apply**. I understand that by refusing to sign the Sliding Fee Discount Program packet and provide proof of income, I am agreeing to submit proof of insurance, or to pay "out of pocket." All charges incurred from this date forward are my responsibility.

Thank you for allowing us to serve your medical, dental, and behavioral health needs.

Patient Name: _____ Patient DOB:_____

Account Guarantor Signature: _____ Date: _____

Payment Acknowledgement is valid for <u>one year from date of signature</u> unless voided by patient or MCPHD.

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Informed Consent for Electronic Communications

Telehealth is defined as the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, health administration, and public health. Telehealth may utilize internet, video conferencing, store-and-forward imaging, streaming media, and land and wireless communications.

By signing this form, I understand the following:

- The health care provider will be at a different location from me.
- The health care or professional health care staff may transmit or share electronically details of my medical history, examinations, x-rays, tests, photographs, or other images during the visit. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed without my consent.
- I understand that I have the right to withdraw my consent to the use of telehealth during my care at any time, without affecting my right to future care or treatment.
- I understand that telehealth may involve electronic communication of my personal medical information.
- A record of the visit will be kept in my medical record.
- I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. The electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.
- This authorization does NOT give permission for MCPHD to engage via social media.
- I consent that MCPHD can provide their services and communicate with me via phone, email, and telehealth software, third-party systems, and other electronic communication platforms, provided that these communications comply with privacy regulations.

I have read and understand the information provided above regarding telehealth and electronic communications. I fully understand the terms of this consent. I hereby give my informed consent for the use of telehealth in my health care.

_____ _____

Patient Signature **Date**
(Parent/Guardian signature if patient is under 18)

_____ _____

Employee Signature **Date**

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Authorization to Release/Obtain Confidential Healthcare Information

Patient name: _____ Date of Birth: _____/_____/_____

Address: _____
(Street) (City) (State) (Zip)

I request and authorize _____ _____ _____
(Doctor or facility releasing records) (Phone) (Fax)

to release healthcare information regarding the above-named patient to:

_____ _____ _____
(Doctor or facility receiving records) (Phone) (Fax)

For the purpose of:

- ☐ Coordinate medical, psychological, and dental services
- ☐ Develop a diagnosis and treatment plan
- ☐ Transfer of care
- ☐ Legal proceedings
- ☐ Patient request

This request and authorization applies to:

- ☐ All healthcare information and records
- ☐ All x-rays
- ☐ Assessments (i.e. AIMS, Connors, Vanderbilt)
- ☐ All dental information, records and x-rays
- ☐ All dental information and records
- ☐ Healthcare information relating to the following treatment, condition, or dates:
  - Treatment or Condition: _____
  - Dates: _____/_____/_____ to _____/_____/_____
- ☐ Other: _____

This release will expire in 365 days unless written revocation is given to the clinical keeper of medical records before the expiration date unless otherwise noted as follows:

Authorization for substance abuse expires on _____/_____/_____ or (condition or event) _____

Authorization for mental health, HIV, STD, or other records expires on _____/_____/_____

PLEASE INDICATE BY INITIALING * MUST BE INITITIALED BY PATIENT IF AGE 12 YEARS OR OLDER *****

_____**YES** _____ **NO** I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above must obtain my specific written permission before disclosing this information to anyone.

_____**YES** _____ **NO** I authorize the release of any record regarding drug, alcohol, or mental health treatment to the person(s) listed above.

I authorize the use or disclosure of my protected health information to Requestor, either verbally, in writing, and/or fax, as described above.

_____ _____/_____/_____
Signature of Patient if age 12 Years or Older (Date Signed)

_____ _____/_____/_____
Signature of Patient or Personal Representative & Relationship (Date Signed)

_____ _____/_____/_____
(Witness Signature) (Date Signed)

For additional information please contact Macoupin County Maple Street Keeper of Medical Records at 217-839-1526.

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Our staff looks forward to treating you and meeting your healthcare needs!

Client Affirmation and Consent to Treatment:

Macoupin County Public Health Centers has given me a copy of the Patient and Client Rights and Responsibilities Form, which explains my rights as a client. This form details my rights under Chapter 2 of the Mental Health and Developmental Disabilities Code and other applicable rights. It explains confidentiality and potential restrictions of confidentiality.

I understand my rights and give my consent for treatment for myself (or my minor child). I know the risks and costs involved in the treatment process, including the nature of the treatment, possible alternatives treatments, and potential risks and benefits of the treatment.

Patient Name (please print): _____ Date of Birth: _____

Patient Signature (12 and older): _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Staff Affirmation:

On _____ I gave a copy of the full patient and client Rights and Responsibilities packet to:

(*date)*

_____ and/or their parent/guardian: _____.

(client name) (*parent/guardian name)*

An explanation of these rights has been provided in a language and method of communication understood by the client, and I believe the client understood his/her rights.

Staff Signature: _____

Please keep pages 2-7

Updated 2/17/22

Patient and Client Rights and Responsibilities

Macoupin County Health Centers patients are encouraged to read this document to understand your rights and responsibilities as a patient. If you have any concerns about your rights or responsibilities, please ask any staff member to contact an administrator directly for assistance.

Interpretation Services will be provided upon request.

Your Patient and Client Rights

Civil Rights

1. Patients have the right to considerate and respectful treatment in an environment free from harm.
2. Patients seeking services shall not be denied, suspended, or terminated from services or have services reduced for exercising any of their rights.

Discrimination

1. Patients have the right to receive services regardless of age, sex, race, creed, color, religion, ethnic origin, ancestry, marital status, physical or mental disability, gender preference, sexual orientation, disability, veteran status, or criminal record.
2. Patients may receive services without regard to one's ability to pay; if you are unable to pay the full fee for services, a sliding fee scale is available to you. You may examine and receive an explanation of your bill of services.
3. No recipient of services is presumed legally incompetent except as determined by a court.
4. Patients have the right to present any complaint or grievance on matters pertaining to services received, or any perceived or actual violation of rights.

Treatment

1. A recipient of services shall be provided with adequate and humane care and in the least restrictive environment, pursuant to an individualized service plan. When appropriate, a recipient's nearest kin or guardian shall be involved in the treatment/service plan.
2. Patients have the right to know of the variety of services that may be available and to participate in the planning of treatment.
3. Patients may refuse treatment at any time, and patients have the right to be informed of the consequences resulting from the refusal of treatment.
4. Seclusion will not be used as a means of intervention for any recipient services.

Confidentiality

1. Patients will receive confidential treatment; all clinical records and client information are protected by law, regulations, and center policies. For the purposes of funding, certification, licensure, audit, research or other legitimate purpose, your clinical record may be used by the person conducting the review to the extent that is necessary to accomplish the purpose of the review.
2. Patient information released to or requested from other sources requires your written consent. Patient records can be subpoenaed by court order and do not require signatures for release of information.
3. Patients have the right to review and obtain a copy of their clinical record in accordance with Macoupin County Public Health Center's policy.

Your Patient Responsibilities

1. Give full information, to the best of your knowledge, about your condition, including symptoms, medications, previous health, etc.

2. Ask questions if you do not clearly understand information or instructions about your care and treatment.
3. Follow the treatment plan coordinated by your physician.
4. Follow through with all referrals given to you for other physician's care.
5. **Notify us immediately of any Emergency Room visits or Hospitalizations** by calling 1-217-839-1526 (leave a message if necessary).
6. **Be responsible for your own actions if you refuse treatment or refuse to follow your treatment instructions and directions. If you refuse to follow the treatment guidelines we provide, we will help you find another physician that may be more effective for you.**
7. **Be patient and be calm. Plan to arrive at the clinic 15 minutes earlier than your appointment time to allow time to complete paperwork that is needed.**
8. Macoupin County Public Health Centers has the right to terminate you from care should you routinely not show-up for appointments or not treat the center's staff with courtesy and respect.
9. Ensure that payment for your care is made promptly and in full; this means understanding your insurance coverage and its limits and any added responsibilities you may have.
10. Follow Macoupin County Public Health Centers rules and regulations.
11. Be considerate of and respectful to your caregivers, other patients, and visitors to the health center
12. Do not possess or use alcoholic beverages or "recreational" drugs in the Macoupin County Public Health Centers or on the Macoupin County Public Health Center's property.
13. Do not have firearms or other weapons in the Macoupin County Public Health Centers or on the center's property.
14. Only certified Service Dogs are allowed in Macoupin County Public Health Centers or on company property.

Macoupin County Public Health Centers Responsibilities

1. In the case of suspected child abuse or neglect Macoupin County Public Health Centers are required by the Abused and Neglected Child Reporting Act to report any suspected incidents of neglect or abuse. Macoupin County Health Centers also has the ethical obligation to report suspected maltreatment of senior citizens or adults.
2. If at any time patients present a clear and present danger to yourself or to others, Macoupin County Public Health Centers staff may release information that is required to protect you or others.
3. Macoupin County Public Health Centers may restrict or terminate delivery of services to patients who have been evaluated and determined as posing a serious physical threat to staff or others.
4. **We will contact you as soon as your results are available. Please, do not call the clinic repeatedly for results.**
5. **Our staff is consistently busy with patients and has a set schedule to work from. Do not expect to have immediate access to a physician, dentist, or other staff when you walk in or call on the phone.**
6. The Macoupin County Public Health Centers staff will work with you on your most urgent health care needs first. We will not always solve all your health care needs with one visit. If you have chronic illnesses, expect to visit your doctor at Macoupin County Public Health Centers on a regular basis.
7. We will schedule you for your next regular check-up during your visit. Remember, the one sure way to stay healthier is to take good care of yourself, keep your medical appointments, and follow your health care team's advice for maintaining your health!

Your Comments and Concerns Are Important to Macoupin County Public Health Centers

We want to hear from you regarding your satisfaction with our care and services, as well as suggestions for improvement. We conduct random patient surveys on an ongoing basis. If you are asked to participate during a visit, please consider taking the time to complete a survey for us. Your comments will help us improve the way we provide care. We also welcome and encourage your comments at any time. All information is used to support our efforts to **continually improve the quality** of your care and safety. Should you have a concern that is unresolved, you have the right to contact the Illinois Department of Financial & Professional Regulations, 320 West Washington Street, Springfield, IL 62786 or by calling 1-888-473-4858.

Should you have questions or concerns regarding your visit to the Macoupin County Public Health Centers, please call our COO at 217-839-1526. Please leave your name, phone number, the day and time you called, and a short message regarding your concern. Our Office Manager will return your call as quickly as possible.

After Hours Contacts

If you need assistance after business hours, please contact our after-hours service at 217-839-1526. The after-hours service will assess your call and direct into the correct person. You will be told that you will be receiving a call from a staff member from Macoupin County Public Health Centers or for non-emergencies, the after-hours service will hold your call for the office the following business day.

Current Office Policies for the Macoupin County Public Health Centers

Appointments: please arrive on time for your appointments. If you are more than **10 minutes** late for a dental appointment or more than **15 minutes** late for a medical or behavioral health appointment, you may be required to reschedule your appointment.

Our waiting room has limited space; please only bring those who will be seen at the appointment. Children are not allowed in the treatment room while their parent is with the dentist and are not permitted to remain unattended in the waiting room area. ***Parents are expected to remain in the waiting room area while their children are with the dentist. If you have any questions or concerns, please speak with the dental assistant.***

Appointments for Dental and Behavior Health: Due to the high volume of patients wanting appointments for these services, we require that you confirm your appointment no later than 2 business days before your scheduled appointment time. If your appointment is not confirmed 2 business days before your scheduled appointment time, we will cancel your appointment.

We have a strict cancellation/no show policy. **All cancellations must be made at least 24 hours before your appointment time.** If you cancel three times within six months or if you fail to cancel at least 24 hours in advance or if you do not show up without notifying us twice within 6 months, you will be placed on the Sit and Wait list. You will be notified by mail of your placement onto the Sit and Wait list. Placement on the Sit and Wait list means that you will not be able to schedule appointments for six months. Any appointments you had scheduled will be cancelled. You will be encouraged to come on Tuesdays and Wednesdays from 9 a.m. to 1 p.m. to sit and wait to see if the dentist has an opening to see you. All appointments must be confirmed at least 2 business days before your appointment date. If your appointment is not confirmed, your appointment will be canceled, and that time will be given to the next patient in line.

Messages: When you call to speak with the dental or medical staff, please leave a message if prompted to do so. Please leave your name, phone number, date of birth, and a brief message and we will return your call as soon as possible. Your phone call will be returned in the order in which it was received.

Insurance: All eligible patients must have their current insurance card to be seen by our medical or dental staff. If we cannot confirm eligibility, we may need to reschedule your appointment.

Co-pay or Prompt Pay: Co-pays and prompt pays are expected at the time of service. To check to see if you have a co-pay, look at the front side of the insurance card. You may be required to reschedule if you do not have the co-pay or prompt pay payment at time of service.

Signed consent to treatment: Our office requires a signed consent form from a parent/legal guardian that gives us permission to perform treatment on the child or adult patients who have a power of attorney or guardian assigned. ***Guardians must accompany patients to initial Dental exams, recall Dental appointments and initial appointment with Medical and Behavior Health Staff.*** However, another adult may accompany minors for subsequent visits if permission is stated on the consent form.

Treatments not performed: At this time, the Macoupin County Health Centers are not able to provide the following services:

Dental - Implants and Orthodontics

Behavioral Health Services

Your rights will be protected in accordance with Chapter 2 of the Illinois Mental Health & Developmental Disabilities Code and your right to confidentiality is governed by the Confidentiality Act and Health Insurance Portability and Accountability Act of 1996. Your rights include:

1. The right to be provided with adequate and humane care in the least restrictive environment.
2. The right to be free from abuse, neglect, and exploitation.
3. The right to have services provided to you following the development of an individual treatment/service plan.
4. The right to have your treatment plan reviewed periodically, but at least once every six months.
5. The right to participate in the development and review of your treatment plan, when appropriate.
6. The right to be notified in writing of the side effects of medication if your treatment plan includes the administration of psycho tropic medication(s).
7. The right to refuse services, including medication, and to be informed of any consequences related to service delivery should you refuse medication.
8. The right to be free from physical restraint/seclusion unless such restraint/seclusion is being used as a therapeutic measure to prevent you from causing physical harm to yourself or others.
9. The right to contact the Guardianship and Advocacy Commission, Equip for Equality, and/or DCFS and DMHDD. You have the right to be offered staff assistance in contacting these organizations.
10. The right to present grievances or appeal adverse decisions related to your services. You have the right to take such grievances to the highest possible level in the agency, including the CEO, the CEO's decision is final. Grievances presented to the provider will be reviewed by the therapist, supervisor, and the COO. A copy of the written response to the grievance will be maintained in the client record as well as presented to the client (or client's guardian). The client has a right to contact the public payer or its designee and to be informed of the public payer's process for reviewing grievances.
11. You are entitled to have your rights explained to you using a language or method of communication you understand upon commencement of services.
12. Services will not be denied, reduced, suspended, or terminated for exercising any of your rights, unless clinically indicated and agreed upon by a separate treatment contract (e.g., Recovery Center Treatment Program).
13. You cannot be denied mental health services because of age, race, sex, religious beliefs, ethnic origin, marital status, social creed, physical or mental disability or criminal record that is unrelated to present dangerousness.
14. You have the right to have disabilities accommodated as required by the Americans with Disabilities Act, section 504 of the Rehabilitation Act and the Human Rights Act (775 ILCS 5).
15. If there is any restriction in your rights it will be documented in your client record and contain a plan with measurable objectives for restoring any rights. Such a plan will be signed by the client affected, his/her parent/guardian, the QMHP and LPHA as applicable, and any agency designated by the client shall be notified of the restriction and given a copy of the plan to remove restrictions of rights.

Additional Rights:

Civil Rights:

1. You have the right to be treated with dignity and respect and to be free from abuse and neglect.

2. You retain all rights, benefits, and privileges guaranteed by law.

Access:

1. Service will be provided with a minimum wait time. Office hours will be reasonably convenient to all consumers requesting services. Efforts will be made to minimize impact of treatment on work time and other legitimate needs.

Confidentiality:

1. All records involving you, and communications to others about you, are confidential and may not be disclosed except under provisions of the DMHDD Confidentiality Act.
2. The following people may, on request, inspect a copy of a client's record to review with provider:
    a. The client, if 12 years of age or older.
    b. The parent (or legal guardian) of a client who is under 12 years old.
    c. The parent (or legal guardian) of a client who is at least 12 but not yet 18, IF the client is informed and does not object or if the therapist does not deny access to the record.
    d. The guardian of a client who is 18 or older.
    e. The attorney or guardian ad litem representing a minor client, if approved by the court or administrative hearing officer.
3. For any information, including whether someone is a client at Macoupin County Public Health Centers to be released to someone other than those listed above requires a written release of information from the applicable party listed above.
4. Records or communications may be disclosed without prior consent to:
    a. The therapist's supervisor or consulting therapist, treatment team staff members, a records clerk, or person acting under the supervision and control of the therapist.
    b. A person conducting peer review of the services provided, such as utilizations review.
    c. An attorney or advocate consulted by the therapist or agency which provides information concerning the therapist's or agency's legal rights and duties in relationship to the client.
5. All staff at Macoupin County Public Health Department Centers are mandated reporters of child abuse and neglect. Illinois state law requires suspicion of child abuse or neglect to be reported to the DCFS child abuse hotline, and this mandate supersedes confidentiality.
6. Therapists have a legal and ethical obligation to protect and prevent harm. If there is a reason to believe a client is placing him/herself or others at substantial risk of harm, the therapist may take steps necessary to prevent the anticipated harm. This may include, for example, seeking police or crisis unit assistance to intervene when a client is suicidal or homicidal. In all such circumstances, therapists will discuss the need with the client unless clinically contradicted or emergency condition preclude such discussion.
7. Any release of information previously signed may be voided by stating so in writing. Such action will prevent further release of information but cannot undo any exchange which has already taken place.
8. Records may be subpoenaed by a court of law. Therapists may be ordered to testify about a client in a court of law.
9. Any restriction of mandated DMHDD client rights, including confidentiality, will be justified, and documented in the client record. The client, his/her parent or guardian, and any agency designated by the client pursuant to section 132.20c(2) or Part 132 (i.e., DCFS, Guardianship and Advocacy Commission, etc.) are to be notified of any applicable client rights restriction, including confidentiality restrictions.
10. Justification for any restriction of a client's rights under statutes cited in subsections 132.142a) or 132.142b) shall be documented in the client's clinical record. The agency (or his/her parent/guardian or agency designated by the client pursuant to subsection 132.142d)2) shall be notified of the restriction.

Treatment:

1. You have a right to an individual treatment plan and will be expected to participate in the development of this plan.
2. You have the right to know the name and professional credentials of anyone working with you.
3. You may request to participate in any staffing regarding yourself.
4. You (age 12 or older) may review your clinical records to review with provider upon written request to this office.
5. You have the right of informed consent regarding all services provided by this office. This includes the right to know the cost of treatment, the nature of treatment, possible alternative treatments, and potential risks and benefits of treatment.
6. You have the right to refuse to participate in, or be interviewed for, research purposes.
7. You have the right to terminate services at any time, unless mandated to treatment by legal or guardian authorities.
8. To receive the highest quality of Behavioral Health Care, we believe that it requires regularly scheduled therapy sessions. To remain an active Behavioral Health patient, you must be seen by your Behavioral Health Therapist at a minimum of once every sixty (60) days. If you are not seen at least once in sixty (60) days, then you will become inactive and must re-establish as a new patient with the Behavioral Health Therapist.

Grievance Procedure:

1. If you feel your services have not been provided fairly or reasonably, you may present your concerns in writing to the COO at 109 E. Maple Street, Gillespie, IL, 62033.
2. You have the right to legal recourse; you have a right to confer with your family, attorney, physician, clergy, or others.

Evaluation:

1. As part of our goal of providing professional and quality services, you will be given the opportunity to evaluate all aspects of your services and the personnel with whom you were involved.

Mutual Responsibilities of Agency and Consumer Service:

1. Deciding on a plan for service.
2. Determining the frequency and duration of consumer involvement.
3. Involving family members and significant others in services.
4. Cooperating to achieve the goals of the treatment plan.

Good Faith Estimate:

You have the right to a "Good Faith Estimate" explaining how much your care will cost

Under the law, health care providers need to give patients who are uninsured or self-pay or who are not using insurance an estimate of the bill for items and services provided by the Macoupin County Public Health Centers.

• You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services.

• Good Faith Estimate will be provided to you in writing before your service or item if scheduled 3-10 business days in advance. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.

• The Macoupin County Public Health Center, as part of the course of care, may recommend additional services that will need to be scheduled or requested separately and are not reflected in the GFE.

• The GFE is only an estimate of items or services reasonably expected to be furnished at the time it was issued, and that actual items, services, or charges may differ from the GFE.

• The GFE is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from the Macoupin County Public Health Centers or any other provider listed.

• The patient may initiate the patient-provider dispute resolution process if the actual billed charges are substantially more than $400.00.

Guardianship and Advocacy Commission (GAC) Equip for Equality:
421 E. Capital Street
Springfield, IL 62701

527 S. Wells, Suite 300
Chicago, IL 60607

427 Monroe Street
Springfield, IL

Department of Mental Health and Developmental Disabilities:
401 S. Spring Street
Springfield, IL 62765
(217) 782-6154
(800) 843-6154
100 W. Randolph Street, Suite 6-400
Chicago, IL 60601
(312) 814-3785