Aunt Martha's Health Center
Patient Registration Form – FAMILY PLANNING

NextGen Record # _____

PATIENT INFORMATION

Today's Date	Last Name	First Name	Middle

Date of Birth	Age	Gender: ❑ Female ❑ Male

Address	City	State	Zip Code

Primary Language:
❑ English ❑ Spanish ❑ Other: _____

Do you have Advance Directives for Health Care? (i.e., Living Will or Power of Attorney)
❑ YES ❑ NO ❑ Not Sure

Social Security Number:
___ ___ ___ - ___ ___ - ___ ___ ___ ___

Marital Status:
❑ Divorced ❑ Legally Separated ❑ Life Partner
❑ Married ❑ Single ❑ Unknown
❑ Widowed

Home Phone Number: (____) _____
May we leave a message at your home phone number? ❑ Yes ❑ No

Daytime Phone Number: (____) _____
May we leave a message at your daytime phone number? ❑ Yes ❑ No

Alternate Phone Number: (____) _____
May we leave a message at your alternate phone number? ❑ Yes ❑ No

Contact Preference:
❑ Home Phone
❑ Daytime Phone
❑ Alternate Phone
❑ No Phone Contact

If the patient is in 8th grade or under, please indicate School District # and School Name. If not, indicate N/A.
❑ 8th grade and under ❑ N/A

School District # _____ School Name: _____

Is the patient enrolled in Illinois Health Connect? ❑ No ❑ Yes ❑ Unsure (Need clarity from Registration Staff)

SPECIAL NEEDS / ADDITIONAL DEMOGRAPHIC INFORMATION

Do you have any of the following impairments?
Sight ❑ No ❑ Yes
Sound ❑ No ❑ Yes
Verbal ❑ No ❑ Yes
Recent Trauma ❑ No ❑ Yes

Educational Mechanism
Verbal instructions given
Written instructions given

Special Religious Concerns
❑ No ❑ Yes
If yes, please explain:
_____

Homeless Status: ❑ Not Homeless ❑ Shelter ❑ Transitional ❑ Doubling Up ❑ Street ❑ Unknown

Migrant Worker Status: ❑ Not a farm worker ❑ Seasonal ❑ Migrant

Language Barrier: ❑ No ❑ Yes

Veteran Status: ❑ No ❑ Yes

Race: ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian ❑ Other Pacific Islander ❑ White

Ethnicity: ❑ Latino/Hispanic ❑ Non Hispanic ❑ Unknown Ethnicity

How did you hear about our services? (check all that apply)
❑ Flyer ❑ Sign ❑ Radio ❑ T.V. ❑ School ❑ Health Fair ❑ Billboards
❑ Mailing ❑ Church ❑ Presentation ❑ Phone Book ❑ Family/Friend ❑ Internet/Website
❑ Current Patient ❑ Dr. _____ ❑ Insurance Plan _____
❑ Hospital _____ ❑ Social Services Agency _____
❑ Aunt Martha's Employee _____

EMERGENCY CONTACT

Emergency Contact Name | Phone Number ( ) | Relationship

RESPONSIBLE PARTY

Parent/Legal Guardian/Responsible Party: **IF SAME AS PATIENT, please check box** ❑

❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.

Last Name | First Name | Middle | Previous Last Name

Date of Birth ____/____/____ Age _____ Relationship to Pt. _____ Gender: ❑Male ❑Female

Address | City | State | Zip Code | County

(_____) Primary Phone Number | (_____) Alternate Phone Number

INSURANCE INFORMATION

Please show your insurance card and picture identification to the receptionist. Income verification is required for all patients, regardless of insurance status.

Person Responsible for Bill: **IF SAME AS PATIENT, please check box** ❑

Is this person a patient here? ❑ No ❑ Yes Is this person covered by insurance? ❑ No ❑ Yes

Last Name | First Name | Date of Birth ____/____/____

Address | City | State

Primary Phone Number | Alternate Phone Number

• PRIMARY INSURANCE

Please indicate primary insurance:

❑ Medicaid ❑ Medicare ❑ Illinois Health Connect ❑ Harmony / HMO ❑ Private Insurance / PPO ❑ None

Policy Holder's Name | Policy/Recipient ID #

$_____ Co-Pay / Deductible Patient's Relationship to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

• SECONDARY INSURANCE

Name of Secondary Insurance (if applicable) | Policy/Recipient ID#

Policy Holder's Name | Relationship to Patient

INCOME VERIFICATION / HEAD OF HOUSEHOLD FAMILY SIZE / INCOME

Family Size: _____ **Family Combined Income**: $_____ Per Week / Month / Year **Annualized Income**: $_____

OFFICE USE ONLY:

Signature Forms

Patient Registration Form is Signed and Dated: ❑YES ❑NO

Medical Consent/HIPAA is Signed and Dated: ❑ YES ❑ NO

Sliding Fee Forms (Uninsured Patients)

Sliding Fee Application: ❑YES ❑NO ❑N/A

Current Income Documentation : ❑YES ❑NO ❑N/A

Current Financial Waive: ❑ YES ❑ NO ❑ N/A

Slide has been assigned: ❑ YES ❑ NO ❑ N/A

Income Re-Certify Date: _____ Staff Signature: _____

Authorization: With my signature I certify that all of the information provided on the patient registration forms is correct to the best of my knowledge. I authorize the release of any medical or other pertinent information necessary to process claims pertaining to Aunt Martha's Health Center visits.

X _____ _____

Signature of Patient / Parent or Legal Guardian **Date**

AUNT MARTHA'S HEALTH CENTER
CONSENT FOR MEDICAL SERVICES

Patient Name _____ Date of Birth _____

I hereby **consent to receive medical services from Aunt Martha's Health Center**. I understand that I may revoke my consent in writing at any time. I also understand that any information regarding my medical history or treatment will remain confidential unless disclosure is required under existing state and federal laws. I consent to the release of my medical history and care to Medicaid, Medicare, Insurance companies, Reviewing and Accreditation Organizations and other Aunt Martha's programs.

_____ _____
Patient Signature Date

_____ _____
Staff Witness Signature Date

If you are requesting Family Planning services please read and sign below:

CONSENT FOR FAMILY PLANNING SERVICES

It is my personal decision to seek and **receive family planning services from Aunt Martha's Health Center**. I consent to the release of my medical history and care to Medicaid, Medicare, Insurance Companies, Reviewing and Accreditation Organizations and other Aunt Martha's programs.

I consent to a physical exam including a general health assessment, pelvic and breast exam.

I consent to lab tests including urinalysis, hematocrit, Pap smear, pregnancy tests and STD screening as medically appropriate.

Note to teens requesting Family Planning services:
While I understand that Family Planning services offered through Aunt Martha's are confidential, Aunt Martha's encourages me to talk to my parents/guardians about the services I'm seeking. It is my responsibility to share this information with my parents/guardians and the staff at Aunt Martha's will assist me should I request their support.

_____ _____
Patient Signature Date

_____ _____
Interviewer Date

Receipt of Advance Directives Information,
Client's Rights and Responsibilities and Notice of Privacy Practices

By signing below, I acknowledge that Aunt Martha's has provided me with a copy of an *Introduction to Advance Directives, Clients Rights and Responsibilities* and *Notice of Privacy Practices*. I have received my copies, I have read and understand the information provided to me.

_____ _____
Patient Signature Date

_____ _____
Staff Witness Signature Date.

PATIENT HEALTH QUESTIONNAIRE

Nine Symptom Depression Check List

(For patients ages 11 and older)

Patient Name: _____ Date: _____

1. Over the ***last two weeks***, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way **	☐	☐	☐	☐

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your doctor or Health Care Clinician. If these kinds of thoughts happen when no one is available, go to a hospital emergency room, or call 911.*

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

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

(For Clinic Staff Only)

Total # of Symptoms: _____

Add columns: _____ + _____ + _____

Total Score: _____

Staff Signature: _____ **Date:** _____

Provider Signature (if applicable): _____ **Date:** _____

Form: PHQ-9

DENTAL HEALTH ASSESSMENT

Name: _____ Today's Date: _____

Phone Number: _____ Date of Birth: _____

In order for Aunt Martha's to provide you quality health care, we need to know about you. Please answer the following questions honestly. Check the appropriate box for each question.

1. When is the last time you had a dental exam?
   - ☐ Less than 6 months ago
   - ☐ 6 months – 1 ½ years ago
   - ☐ More than 1 ½ years ago
   - ☐ I don't know

2. When is the last time you had your teeth cleaned?
   - ☐ Less than 6 months ago
   - ☐ 6 months – 1 ½ years ago
   - ☐ More than 1 ½ years ago
   - ☐ I don't know

3. Do your gums bleed when you brush your teeth?
   - ☐ Yes
   - ☐ No
   - ☐ I don't know

4. Do you have pain in your mouth?
   - ☐ Yes
   - ☐ No
   - ☐ I don't know

ASESORAMIENTO DE SALUD DENTAL

Nombre: _____ *Fecha de hoy:* _____

Número de teléfono: _____ *Fecha de nacimiento:* _____

Para que Aunt Martha's pueda proveerle calidad en su atención médica, por favor conteste las siguientes preguntas con honestidad. Marque la respuesta para cada pregunta.

1. *¿Cuándo fue la última vez que usted tuvo un examen dental?*
   - ☐ *Menos de 6 meses*
   - ☐ *6 meses – 1 ½ años*
   - ☐ *Mas de 1 ½ años*
   - ☐ *No sé*

2. *¿Cuándo fue la última vez que usted tuvo una limpieza de dientes?*
   - ☐ *Menos de 6 meses*
   - ☐ *6 meses – 1 ½ años*
   - ☐ *Mas de 1 ½ años*
   - ☐ *No sé*

3. *¿Sus encías sangran cuando se cepilla los dientes?*
   - ☐ *Sí*
   - ☐ *No*
   - ☐ *No sé*

4. *¿Tiene usted dolor en la boca?*
   - ☐ *Sí*
   - ☐ *No*
   - ☐ *No sé*

For office use only

Reviewed by: _____ (Signature) _____ (Date) Referred? ☐ Yes ☐ No

Revised: 6/13/12

AUNT MARTHA'S HEALTH CENTER

INITIAL HEALTH ASSESSMENT

Date:	Name:	
Phone#:	DOB:	Age:

How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Main reason for today's visit: _____

Other concerns: _____

REVIEW OF SYMPTOMS: Please check any current symptoms you have.

Constitutional
- ☐ Recent fevers/sweats
- ☐ Unexplained weight loss/gain
- ☐ Unexplained fatigue/weakness

Eyes
- ☐ Change in vision

Ears/Nose/Throat/Mouth
- ☐ Difficulty hearing/ ringing in ears
- ☐ Hay fever/allergies/congestion
- ☐ Trouble swallowing

Cardiovascular
- ☐ Chest pains/discomfort
- ☐ Palpitations
- ☐ Short of breath with exertion

Breast
- ☐ Breast lump
- ☐ Nipple discharge

Respiratory
- ☐ Cough/wheeze
- ☐ Coughing up blood

Gastrointestinal
- ☐ Heartburn/reflux
- ☐ Blood or change in bowel movement
- ☐ Nausea/vomiting/diarrhea
- ☐ Pain in abdomen

Genitourinary
- ☐ Painful/bloody urination
- ☐ Leaking urine
- ☐ Nighttime urination
- ☐ Discharge: penis or vagina
- ☐ Unusual vaginal bleeding
- ☐ Concern with sexual functions

Musculoskeletal
- ☐ Muscle/joint pain
- ☐ Recent back pain

Skin
- ☐ Rash
- ☐ New or change in mole

Neurological
- ☐ Headaches
- ☐ Memory loss
- ☐ Fainting

Psychiatric
- ☐ Anxiety/stress
- ☐ Sleep problem

Blood/Lymphatic
- ☐ Unexplained lumps
- ☐ Easy bruising/bleeding

Endo
- ☐ Cold/heat intolerance
- ☐ Increase thirst/appetite

PERSONAL MEDICAL HISTORY:

Do you have any of the following problems?
- ☐ Acid reflux (heartburn)
- ☐ Alcoholism/other addiction
- ☐ Allergies (environmental)
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Cancer (specify type_____)
- ☐ Coagulation (bleeding or clotting) problem
- ☐ Cholesterol problem
- ☐ Chronic low back pain
- ☐ Depression
- ☐ Diabetes mellitus
- ☐ Erectile dysfunction
- ☐ Heart disease (specify type_____)
- ☐ Hypertension (high blood pressure)
- ☐ Irritable bowel syndrome
- ☐ Migraines
- ☐ Osteopenia or Osteoporosis
- ☐ Prostate problem
- ☐ Thyroid problem
- ☐ Other problems (please list): _____

Have you ever had any of the following problems? If so, please provide approximate year:

Cancer of _____ (Please specify) Heart attack _____ Blood transfusion _____

Stroke (CVA) _____ Seizure _____

SURGICAL HISTORY: Please list all prior operations and dates. ☐ I have had no prior surgery.

Operation	Date

Operation	Date

AUNT MARTHA'S HEALTH CENTER

INITIAL HEALTH ASSESSMENT

(continued)

Name:	DOB:

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs.

☐ **I take no regular medications.**

Medication	Dose	Times per day

Medication	Dose	Times per day

ALLERGIES or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS:

☐ **I am not allergic to any medications.**

Medication	Reaction or Side Effect

FAMILY HISTORY:

Please indicate with a check (✓) family members who have had any of the following conditions:

☐ **I do not know my family history.**

Medical Condition	Mom	Dad	Sister	Brother	Daughter	Son	Other close relatives
Alcoholism	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐
Anesthesia problem	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Birth Defects	☐	☐	☐	☐	☐	☐	☐
Bleeding problem	☐	☐	☐	☐	☐	☐	☐
Cancer, Breast	☐	☐	☐	☐	☐	☐	☐
Cancer, Colon	☐	☐	☐	☐	☐	☐	☐
Cancer, Melanoma	☐	☐	☐	☐	☐	☐	☐
Cancer, other skin	☐	☐	☐	☐	☐	☐	☐
Cancer, Ovary	☐	☐	☐	☐	☐	☐	☐
Cancer, Prostate	☐	☐	☐	☐	☐	☐	☐
Cancer, (not noted)	☐	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Diabetes, Type 1 (child)	☐	☐	☐	☐	☐	☐	☐
Diabetes, Type 2 (adult)	☐	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐	☐
Epilepsy (Seizures)	☐	☐	☐	☐	☐	☐	☐

Medical Condition	Mom	Dad	Sister	Brother	Daughter	Son	Other close relatives
Genetic diseases	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐
Hay fever (Allergies)	☐	☐	☐	☐	☐	☐	☐
Hearing problems	☐	☐	☐	☐	☐	☐	☐
Heart Attack (CAD)	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐	☐	☐
Kidney diseases	☐	☐	☐	☐	☐	☐	☐
Lupus (SLE)	☐	☐	☐	☐	☐	☐	☐
Mental retardation	☐	☐	☐	☐	☐	☐	☐
Migraine headaches	☐	☐	☐	☐	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐	☐	☐	☐
Stroke (CVA)	☐	☐	☐	☐	☐	☐	☐
Thyroid disorders	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐

AUNT MARTHA'S HEALTH CENTER

INITIAL HEALTH ASSESSMENT

(continued)

Name:	**DOB:**

REPRODUCTIVE HISTORY:

MENSTRUAL HISTORY

Age when periods started: _____years. Number of days between periods: _____days.
Period duration: _____days of bleeding. Flow: ☐ Light ☐ Med ☐ Heavy
Date of last menstrual period:_____ Certainty of last period: ☐ Sure ☐ Unsure
Method of birth control: ☐ Condoms ☐ Pills: Name_____ ☐ IUD ☐ Depo-Provera
☐ Nuva Ring ☐ Implanon ☐ Diaphragm ☐ Tubes tied ☐ Ortho Evra Patch
Breakthrough bleeding? ☐ Yes ☐ No Do you pass clots? ☐ Yes ☐ No
Mood swings around time of period? ☐ Yes ☐ No Previous diagnosis of: ☐ Polycystic Ovaries ☐ Endometriosis

ARE YOU ARE POST-MENOPAUSAL? ☐ Yes ☐ No
Age at menopause: _____years.
Hormone replacement therapy ever? ☐ No ☐ Yes Type: _____ # of years: _____ Hot flashes? ☐ Yes ☐ No

ANY PREGNANCY HISTORY INCLUDING TUBAL & MISCARRIAGE

# of total pregnancies:_____ ☐ Full-Term ☐ Premature # of miscarriages: _____ # of abortions: _____
Tubal pregnancy? ☐ Yes ☐ No # of multiple pregnancies (twins): _____ # of C-Sections: _____ # of living children: _____

PAP HISTORY

Date of last PAP: _____ Normal? ☐ Yes ☐ No
Any abnormal PAPs? ☐ Yes ☐ No Date and treatment: _____
Where was PAP done? _____
Did your mother take DES while pregnant with you? ☐ Yes ☐ No ☐ I Do Not Know

SOCIAL HISTORY:

Job Title: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Separated ☐ Engaged
Exercise: ☐No ☐ Yes ☐ Active, but no formal exercise ☐ Heavy, 4 or more times per week ☐ Moderate, 1-3 times per week
☐ Minimal ☐ Sedentary

Tobacco use: ☐ Yes ☐ No Type: _____ # per day _____ for _____ years. Quit? ☐ Yes When _____
Alcohol use: ☐ Yes ☐ No Type: _____ # per day _____ for _____ years. Quit? ☐ Yes When _____
Illegal substance abuse: ☐ Yes ☐ No Type: _____ Frequency _____ for _____ years.
Quit? ☐ Yes When _____
Caffeine use: (tea, coffee, soda) ☐ Yes ☐ No Type: _____ # per day _____ for _____ years.

Are you sexually active? ☐ Yes ☐ No Age of first encounter: _____
Has anyone ever forced you to have sex? ☐ Yes ☐ No if **yes**, please describe: _____

Have you had sex without protection because your partner did not want to use protection (even though you wanted to use protection)? ☐ Yes ☐ No If **yes**, please describe: _____

Does your partner listen to you? ☐ Yes ☐ No Does your partner respect your wishes? ☐ Yes ☐ No If **no**, please describe:

Have you ever had too much to drink and been sexually active even though you didn't want to? ☐ Yes ☐ No If **yes**, please describe: _____

Have you experienced a sexual activity that did not feel good, hurt you, or frighten you? ☐ Yes ☐ No If **yes**, please describe:

Has your partner or someone important to you emotionally or physically abused you? ☐ Yes ☐ No If **yes**, please describe:

Are you afraid of your partner or anyone else? ☐ Yes ☐ No If **yes**, please describe: _____

AUNT MARTHA'S HEALTH CENTER

INITIAL HEALTH ASSESSMENT

(continued)

Name:	**DOB:**

CONTACT INFORMATION:

Test results are returned to the clinic in approximately 10 to 14 days from the date of your exam. If your test results are abnormal or require additional testing, the clinic will contact you in one of the following ways. **Please check one**. Clinic staff will call you at home.

- ☐ If you are not available they will leave a message that "Aunt Martha's Clinic" called.
- ☐ If you are not available they will leave a message that "Tiffany" called. It will be your responsibility to contact the clinic.
- ☐ I do not want to be contacted under any circumstances by the clinic. I understand it is my responsibility to contact the clinic in 10 to 14 days to obtain my test results.

Phone number: _____ Pager number: _____
Is this your number or a message number? ☐ Mine ☐ Message

If the above method does not result in contact, a certified letter will be sent to the address that you have provided requesting you contact the clinic. If you have tested positive for a sexually transmitted disease, and we have been unable to reach you for treatment, the State will be notified. The State will contact you and provide necessary treatment.

Client Initials: _____

I have received the health education packet. I will/can participate in my treatment plan. I have had the opportunity to ask questions regarding my health and my treatment plan. To the best of my knowledge the above information, the information I shared in the interview and during my exam is honest and correct.

_____ _____
Client Signature Date

_____ _____
Interviewer Signature Date

_____ _____
Clinician Signature Date

AUNT MARTHA'S HEALTH CENTER
An Introduction to Advance Directives:
Living Will and Durable Power of Attorney for Health Care

What is an Advance Directive?

An Advance Directive is a document that allows you to:

- To express your wishes about your healthcare in a form that will tell others how to care for you if and when the time comes that you are unable to make or communicate decisions for yourself.
- To give an "advance directive" means:
  - To give your directions ahead of time
- Two types of advance directives:
  - The Living Will
  - The Durable Power of Attorney for Health Care

Why is it a Good Idea to Have an Advance Directive?

An advance directive can help you prepare for decisions about medical care or life-threatening illness by declaring your wishes now.

If you choose not to have an advance directive, it is beneficial to discuss your wishes with persons (such as a guardian, spouse, adult children, and others close to you) who may be able make medical decisions on your behalf.

What is a Living Will?

- A written statement of your wishes regarding medical treatment if you have a terminal condition and death is imminent and you are unable to make decisions for yourself;
- If you are at the end of a terminal illness, allows you to choose the type of care you do or do not want (from among the reasonable and ethical medical care options offered by your doctor);
- Can provide instructions to your healthcare providers regarding your medical care if you are terminally ill, even if you do not wish to appoint a specific individual to serve as your agent under a Durable Power of Attorney for Health Care;
- Can be changed or revoked by you at any time;
- Is a document you are advised to share with one or more of the following persons:
  - A family member or close friend
  - Your doctor
  - Your lawyer
  - Your designated "agent" (your Durable Power of Attorney for Health Care) if you have one

What is a Durable Power of Attorney for Health Care?

A Durable Power of Attorney for Health Care is:

- A written document that you can use to appoint a person of your choice (your "agent") who understands and agrees to make healthcare decisions for you;
- Becomes effective at whatever point in time that you state in your document, and as such
  - Can apply to a wide range of healthcare decisions (and is broader than a living will, which applies to terminal illness)
  - Allows you to rely on a trusted individual to decide what is best for you
- Concerns medical care decisions:
  - That you do not wish to make for yourself for whatever reason, or
  - That must be made when you are very sick and unable to communicate decisions for yourself
- Requires your agent to honor your wishes about healthcare as you have instructed
- Can be changed or revoked by you at any time

Where Can I Get More Information?

For information about different types of advance directives (Living Will, Durable Power of Attorney for Health Care, Do Not Resuscitate orders (DNR), refer to the following sources:

1. Your lawyer or legal aid service
2. Your county or state health department
3. Illinois Department of Public Health
   - Email: www.idph.state.il.us
   - Phone: 217-782-4977
   - Fax: 217-782-3987
   - Mail: 535 W. Jefferson St.
     Springfield, IL 62761

AUNT MARTHA'S HEALTH CENTER
CLIENT'S RIGHTS AND RESPONSIBILITIES

Aunt Martha's Health Center is dedicated to providing clients with the best possible care to meet their identified needs. To accomplish this, we believe it is critical to include our clients and parents/legal guardians, when applicable, in all decisions that directly impact our team.

It is the duty of Aunt Martha's staff to inform you of your rights and program responsibilities before the commencement of services in a language or method of communication that you will understand. These rights are protected and promoted by agency staff.

- You have the right to Confidentiality of information which is governed by the Health Insurance Portability and Accountability Act of 1996 and state law where applicable. Your personal information will be used only as described in the Notice of Privacy Practices, unless written authorization is given to you or your legal guardian, if applicable, except as required by law.
- You have the right to be informed of the nature, availability (including hours which care is available) and goals of all services to which you are otherwise entitled through the agency or other resources.
- You have the right to receive services with adequate and human care in the least restrictive environment.
- You have the right to receive services regardless of age, sex, race, religious belief, ethnic origin, or impairment. However, if you are under the age of 18, your parent or legal guardian's permission is needed, unless you are seeking Family Planning services and you are 12 years of age or older.
- You have the right to be free from abuse, neglect, or exploitation. You will not be subjected to any type of punishment that violates your rights such as corporal punishment, ridicule, humiliation, verbal abuse, or any other means of discipline which would lessen your sense of dignity and value as a person.
- You have the right to view your client record and examine its contents in the presence of a staff member qualified to interpret the file contents. You may request that a statement of clarification be included in your record should you find any discrepancies.
- You or your legal guardian have the right to file a grievance or appeal decisions of the provider up to and including the executive director or comparable position and be informed of the outcome of the petition.
- You or your legal guardian has the right to refuse services, including medications. You will be informed of alternative services available and the risks of such alternatives, if any, as well as the possible consequences of refusal of such services.
- Treatment and/or services will not be denied, reduced, suspended, or terminated for exercising any of your rights.
- You will be made aware of any fees or payment policies that pertain to the services provided. In clinical programs, an inability to pay will not be the sole determining factor in your admission or discharge from any services.
- You have the right and responsibility to be involved in any and all care decisions.
- You have the right to be informed about any financial programs related to your care, treatment, or services.
- You have the responsibility to provide relevant information to clinic staff and to the physician or medical provider to the extent that you are able.
- You have the responsibility to ask questions if you do not understand instructions that are given to you.
- You have the responsibility to accept consequences that may occur as a result of decisions that you make, actions that you take, or inaction.
- You have the responsibility to follow rules and regulations specific to our facility.
- You have the responsibility to show respect to other patients and staff.
- You have the responsibility to make an effort to pay treatment related bills for which you are responsible.

NOTICE OF PRIVACY PRACTICES

Aunt Martha's Health Center is a covered entity under HIPAA (Health Insurance Portability and Accountability Act). As a covered entity, Aunt Martha's is committed to ensuring that your private health information is treated confidentially. This notice describes instances when your health information may be disclosed (used outside of Aunt Martha's). Other than the disclosures described in this notice, your health information will not be disclosed without your signed authorization.

Use of Information for Treatment, Payment and Operations

1. In order to provide good medical care to you (treatment), obtain payment for services (payment), and ensure quality and efficiency in our daily functions (operations), there will be times when we must share information outside of this organization:
    a. An example which may occur under treatment would be calling a physician or hospital to which we are referring you and providing them with information about your condition.
    b. For payment purposes, we might send information to your insurance company, required in order to process your bill.
    c. For operations, we might allow your chart to be reviewed by an external reviewer or auditor.
2. In the above instances, your personal health information may be disclosed. Under each of these circumstances, the entities that review your information will be either bound by federal law or otherwise have a responsibility to keep your personal information confidential.
3. Information that we may release under these circumstances would not be limited to and could include information regarding HIV infection, substance abuse, and /or psychiatric illness.
4. You may request restrictions beyond those stated in this notice but our organization is not required to abide by the restrictions requested unless we agree to do so.

The Right to Inspect and Amend Records

- You have the right to inspect your medical/client record or any other document owned by Aunt Martha's that contains your personal health information with rare exceptions.
- If you believe that any information inspected is inaccurate, you have the right to request that the information be changed so that it is accurate.
- A request to inspect or amend your health information must be in writing. Should you make such a request, it will be evaluated by Aunt Martha's Privacy Officer or designee to determine if the request to inspect your health information and/or the requested change in your health information should be allowed.
- You will be informed of a decision (for inspection or amendment/change of record) within a reasonable period of time.
- If a decision is made to change the information as requested, an effort will be made to inform other entities who may receive inaccurate information.
- However, if it is determined that no change is warranted, you will be informed of this decision as well. You may appeal this decision by resubmitting the request for the change in writing and stating in that request that you are now appealing a previous decision.
- Upon receipt of the second request, the records will be reevaluated by a licensed physician who was not involved in your treatment or in the decision to deny the initial request. The decision at this second level of review will be final.

Disclosure of Research

- It is possible that your health information might be accessed by a researcher.
- Such access will not be allowed under any circumstances unless the researcher has clearly demonstrated that your heath information will be treated confidentially and that protective measures are put in place to ensure that unauthorized access does not occur.
- In these situations, if feasible, you will be contacted and your permission will be asked to allow your information to be utilized for this purpose.
- Whether you allow or don't allow your information to be used, your services at Aunt Martha's will not be affected. Your treatment will in no way be conditioned upon your approval.

- In situations where it is feasible to obtain your approval, your information may still be used (but not in instances where you have requested that your information not be used) provided that the researcher has demonstrated that appropriate steps will be taken to protect your identity, that protective measures are in place to prevent unauthorized access, and that any information pertaining to your identity will be destroyed as early in the research as possible.
- Any disclosure beyond that described above will generally require you to sign an authorization form except under rare and extenuating circumstances.
- Aunt Martha's has formed a Corporate HIPAA Compliance Committee which is responsible for overseeing the implementation of Aunt Martha's HIPAA compliance efforts and ensuring that your personal health information is treated confidentially. Members of this committee, including those who are responsible for investigating complaint, are listed below:
    - Chief Executive Officer — Raul Garza
    - Medical Director — Jennifer Byrd
    - Complaint Recipient — Ernest Gonzalez

- You may submit a complaint verbally or in writing to either the complaint recipient or to this location. If you leave a voicemail message, include your name, patients/client's name and details about the complaint.
- Furthermore, at your discretion, you may complain to any members of the committee listed above. Additionally, if you believe that your rights to privacy have been violated, you have the right to complain to the Secretary of the Department of Health and Human Services in the Office of Civil Rights.
- This privacy notice may be subject to change. If a change should occur, the change will be posted in our waiting area and on our website at the time of implementation or as soon as possible after implementation. You may request a current notice at any time verbally or in writing.