REGISTRATION FORM

Date: ______________________ PCP: ______________________ MR#: ______________________

PATIENT INFORMATION

Name: ______________________________________ Maiden Name ______________________
Last First MI

Is this your legal name? ☐ yes ☐ no If not, what is your legal name? ______________________

Address: ____
Street City State Zip Code

Do you live in Public Housing? ☐ yes ☐ no Are you a Veteran? ☐ yes ☐ no

Home Phone: ________________ Work: ________________ Cell Phone: ________________

Email Address ____________________________________

Social Security #: ______________________ Birth Date: ______________ Gender: ☐ male ☐ female

Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed

Race: ☐ White ☐ Asian ☐ other: ____________ ☐ African American

Ethnicity: Are you Latino/Hispanic? ☐ yes ☐ no

Preferred Language: ______________ Monthly Family Income: ______________ Family Size: ________

Name of Parent or Guardian: ______________________________ Phone: ________________

INSURANCE INFORMATION

Subscriber's Name: ____
Last First MI

Subscriber's Social Security #: ______________________________ Birth Date: ________________

Insurance Name: ____

Group #: ______________________________ Policy #: ______________________________

Patient's relationship to subscriber: ☐ self ☐ spouse ☐ child ☐ other ______________________

Name of secondary insurance (if applicable): ________________ Subscriber's Name: ________________

Group #: ______________________________ Policy #: ______________________________

EMERGENCY CONTACT

Name: ______________________________________ Relationship: ______________________
Last First MI

Home Phone: ________________ Work: ________________ Cell Phone: ________________

CONTACT PREFERENCES

You can mail test results and other correspondence to my home: ☐ yes ☐ no
You can call me to notify me of appointments or discuss results: ☐ yes ☐ no
Please list any other persons in your home with whom we can share your medical information:

Name: ______________________________________ Relationship: ______________________

Name: ______________________________________ Relationship: ______________________

Patient/Guardian Signature: ______________________________________ Date: ________________

Entered by: ________________

Patient Name ______________________________

Date of Birth ______________________________

CONSENT FOR DIAGNOSIS AND TREATMENT
I hereby authorize this health center to administer such diagnostic procedures, test and treatments which may be deemed necessary and advisable by the attending physician (including residents) for the above named patient. I further understand that the attending physician is responsible for determining the course of treatment. I am also aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatment or examination in the health center. I also authorize this health center to retain, preserve and use for scientific or teaching purposes, or dispose of, any specimens or tissues taken from my body during the course of services rendered**. I am aware of electronic medication prescribing and give the providers at Esperanza Health Centers consent to access my electronic medication history. I authorize Esperanza Health Centers to contact me by mobile phone.**

AUTHORIZATION FOR RELEASE OF INFORMATION
I hereby authorize Esperanza and its physicians to release any medical records or other information to my insurance carrier, Medicare, Medicaid, health plans, employer insurance groups, and to any utilization/certification/authorization organization acting on their behalf, to obtain reimbursement on my behalf for the treatment rendered to me by Esperanza and its physicians. I understand that I may revoke this authorization in writing at any time for any reason except to the extent that action has already been taken. If not previously revoked this consent will be valid until my bills are paid and/or utilization review has been completed.

I understand that I am placing no limitation on the release of medical records, to the above referenced agencies, in terms of dates of service, history of illness or diagnostic and therapeutic information including mental health, alcohol and drug abuse treatment and/or Acquired Immune Deficiency Syndrome (AIDS)/HIV testing.

ASSIGNMENT OF BENEFITS/GUARANTEE OF PAYMENT
In consideration of Esperanza and medical services rendered by Esperanza and the provider(s), I hereby assign to all my rights and claims for reimbursement under any health insurance policy, Medicare, Medicaid, or group accident or health insurance for which benefits may be available for payment of the services provided.

I understand that I am responsible to conform to any requirements of my insurance company or managed health care plan for referral from my primary care physician, authorization, notification, and pre-certification and that I am responsible for the payment of any reductions in payment by my insurance because of a failure to meet the requirements.

If my medical insurance coverage is not sufficient to satisfy the health center and physician charges in full, I acknowledge that I am fully responsible for payment of the balance due of all charges not paid for by the above mentioned coverage (excluding those charges not collectable pursuant to Medicare regulation). This may include costs of collection and/or reasonable attorney's fees.

I certify the family income and family size provided by me is accurate. I have also been informed of the sliding scale guidelines and I have been given the sliding scale discount I qualify for based on federal poverty guidelines.

PATIENT RESPONSIBILITIES
I understand that it is my responsibility to keep my appointment. I also understand that if I miss or cancel my appointment for any reason that I am responsible for contacting the health center to reschedule an appointment. I understand that if I arrive more than 15 minutes late for my appointment, I may have to reschedule for another day or wait to see if I can be worked in.

I understand that all lab work ordered by my provider is for the benefit and greater understanding of my current and ongoing health status. If I am unable to pay for or choose not to have lab work done within the time parameters designated by my provider it is my responsibility to request to speak with my provider to discuss alternative methods. I understand that if I choose to return on another day to have my lab work done that it is my responsibility to return to the clinic for this lab work. I understand that it is not the responsibility of the health center to call, mail or otherwise attempt to contact me with a reminder of orders pending. I further understand that I may attempt to have lab work done at another facility at my own cost and that it is my responsibility to bring records of these results to my next clinic appointment so that my provider may have the most accurate information regarding my health status.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE FOREGOING, AND IS THE PATIENT OR IS DULY AUTHORIZED TO ACCEPT THE ABOVE TERMS ON THE PATIENT'S BEHALF. ADDITIONALLY HE/SHE CERTIFIES THAT HE/SHE HAS RECEIVED A COPY OF ESPERANZA'S WELCOME PACKET AND NOTICE OF PRIVACY PRACTICES.

______________________________ Signature of Patient/Responsible Party ______________ Date

______________________________ Relationship to Patient ______________________________ Reason why patient did not sign

______________________________ Witness ______________ Date

ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

The undersigned patient or legally authorized representative ("Agent") of the patient acknowledges that he or she personally received a copy of the Esperanza Health Centers Notice of Privacy Practices on the date indicated below.

Patient Signature Date

Signature of Guardian (if patient is a minor) Date

Signature of Witness Date

CERTIFICACIÓN DE RECIBO DE AVISO
SOBRE PRÁCTICAS DE PRIVACIDAD

La firma del paciente o del representante legalmente autorizado ("Agent") del paciente certifica que el o ella ha recibido personalmente una copia de las Prácticas de Privácidad del Esperanza Health Centers, en la fecha abajo indicada.

Firma del Paciente Fecha

Firma del Guardián (si el paciente es menor de edad) Fecha

Firma del Testigo

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed for the purpose of providing health care services to you, to pay your health care bills, to support the operation of our practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you or your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed to obtain payment for your health care services. For example, we may provide your protected health information to your health plan to obtain payment for services.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to run our practice, improve your care, and contact you when necessary. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Uses and Disclosures Which Do Not Require Your Authorization: We may use or disclose your protected health information in the following situations without your authorization: as required by law; for certain public health and safety issues, including the reporting of communicable diseases and suspected abuse, neglect, or domestic violence; in response to a court or administrative order or subpoena; to coroners, funeral directors, or medical examiners upon the death of an individual; to organ or tissue procurement organizations; for worker's compensation claims, law enforcement and special government functions, such as national security and health oversight purposes. We can also share your information for certain health research. We may disclose your protected health information to the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the federal privacy laws.

Uses and Disclosures to Individuals Involved in Your Care or Payment for Your Care: If family members, relatives, or friends are helping to care for you or pay for your medical costs, we may release protected health information to them unless you object. This information will be limited to that necessary to pay for your care or to care for you. We also may provide your protected health information to a disaster relief organization to allow your family to be notified about your condition and whereabouts in a disaster. In an emergency situation where you may not be able to object, we may share your information if we believe it is in your best interest. We also may share your information when necessary to lessen a serious and imminent threat to health or safety.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke such authorization at any time in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization. Uses and disclosures of your psychotherapy notes, if any, uses and

disclosures of your protected health information for marketing purposes, and disclosures that constitute a sale of your protected health information only will be made with your written authorization, unless otherwise permitted or required by law, as described in this Notice.

We may contact you to raise funds for our organization and you have the right to opt out of receiving fundraising communications.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits such access. We may charge a reasonable, cost-based fee for copying or postage. You may not remove our records from the premises. If we maintain your information electronically, we can provide you with the protected health information in a mutually agreeable readable electronic form and format upon your request.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or payment for your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

We are not required to agree to a restriction in all circumstances, but we will agree to a restriction for disclosures to a health plan if (1) the disclosure is for the purpose of carrying out payment or health care operations and (2) the protected health information pertains solely to a health care item or service for which you, or a person other than the health plan on your behalf, has paid us in full. If we agree to a restriction on the use or disclosure of your protected health information, we must comply with such restriction, other than in an emergency or certain other circumstances permitted or required by law.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate all reasonable requests.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e., electronically.

You may have the right to request an amendment of your protected health information. If we deny your request for amendment, you may file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures. We will provide one accounting per year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

You have the right to be notified of a breach. We are required by law to notify you following a breach that may have compromised the privacy or security of your unsecured protected health information.

You have the right to choose someone to act for you. If you have given someone medical power or attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we will take any action.

We are required to abide by the terms of this Notice currently in effect. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw notice.

Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact (Maria Fragoso 773-584-6148) of your complaint. **We will not retaliate against you for filing a complaint.**

Welcome

Welcome and thank you for selecting **Esperanza Health Centers** as your medical home! We are a community health center that practices the *Patient Centered Medical Home Model*. Esperanza's mission is to promote healthy lifestyles and improve health status through the provision of high quality health care and wellness services. We are here to take care of your family, a role that gives us great pride!

Our Services

We provide a number of services at our two locations including pediatrics, internal medicine, family medicine, women's health/ obstetrics, behavioral health and allergy/immunology. All of our full-time providers and our clinical staff are bilingual and bicultural. Our health center offers services for lab, EKG's and ear piercing. There is also a third party pharmacy on site that makes home deliveries at your request.

After Hours Care

If you need to reach your provider after business hours for urgent matters, please call 773.584.6200 and someone from the Esperanza team will receive your message. If it's life threatening please call 911.

What are Care Teams?

A care team is a group of people (provider, patient, medical assistant, patient service representative) that works together to ensure you are healthy. As you are also a major part of the care team, it is important that you keep us informed of any changes in your health. Please let us know of any visits to the hospital, specialist or other medical services received outside the health center. Please inform us of any new medications you are taking. All of this information is important so we know how you are doing in-between your visits to Esperanza. The more we know, the better care we can provide for you and your family.

For an appointment please call us at 773.584.6200

Esperanza California
2001 S. California Ave.
Chicago, IL 60608

Esperanza Little Village
3059 W. 26th St.
Chicago, IL 60623

Esperanza Marquette
6550 S. Richmond
Chicago, IL 60629

Visit esperanzachicago.org

Find us on Facebook!

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Important Information

Missed Appointments or Cancellations

As a part of the care team, it is important that you keep track of all scheduled appointments. If you are unable to keep an appointment, please call 773.584.6200 to cancel or reschedule.

Refills

Please call your pharmacy at least one week in advance to requests refills to ensure you do not go without any medication. Our goal is to refill medication requests within 2 business days.

Referrals

We schedule all referral appointments unless you request to schedule your own. Most referrals are processed within 14 days of your visit. If you have not heard back from Esperanza within 2 weeks of your visit, please call and ask to speak to the providers' medical assistant. If your referral is specifically to Cook County/ Stroger Hospital, please call us at 773.932.1016.

Chronic Care

Patients with chronic conditions like diabetes, high blood pressure and asthma should schedule their follow-up appointment before leaving the office.

Routine Appointments

If your provider requests to see you within a year, please schedule an appointment before leaving the office.

Phone Calls

All phone calls will be returned within 48 hours

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