RURAL HEALTH, Inc.

We specialize in you

Anna Main / Dongola / Goreville / Metropolis / Vienna

Even when we are not here……we have you covered

Did you know you can reach a medical provider 24/7 by simply calling the office? Your call will be connected to an answering service who will contact the Rural Health, Inc. medical provider if indicated.

If you are experiencing a medical emergency, call 911 or go to your nearest emergency room.

Cuando no estamos aquí ..... lo pudemos cubrir.

¿Sabía usted que usted puede alcanzar a un doctor médico 24/7 por simplemente llamando la oficina? Su llamada estará relacionada con un servicio de contestación automática quién se pondrá en contacto con el Rural Health, Inc doctor médico como indicado.

Si usted tiene una urgencia médica, llame 911 o vaya a su cuarto de emergencia más cercano.

******The after-hours answering service for Rural Health, Inc. offers over 350 languages to serve you better.***

OB/GYN • MEDICAL • DENTAL • PSYCHIATRY

RURAL HEALTH, Inc.

We specialize in you

We value your input and want to hear about your experience as a Rural Health, Inc. patient.

This is your opportunity to tell us what we did well and where we need improvements.

*Please provide us your **email** and you will receive a patient satisfaction survey following your visit with us.*

Thank you for helping us grow……

RURAL HEALTH, Inc.
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Initial _____

PATIENT REGISTRATION FORM

Please provide a driver's license or picture identification card, along with current insurance cards and any copay due at time of service

Last Name:_____First Name:_____

First name used: _____ Middle name, suffix_____

Previous Name (last, first):_____

Legal Sex: ( ) Male ( ) Female Date of Birth: ____/____/_____

Social Security Number:_____ Mother's maiden name:_____

Email:_____@_____

Access to Patient Portal: [ ] Yes [ ] No

Patient Home Address:_____

Mailing Address:_____

City_____State_____Zip_____

Driver's License Number:_____State_____Expiration Date_____

Patient Phone: Home ( )_____-_____ Cell ( ) _____-_____ Work ( ) _____- _____

Consent to text [ ] Yes [ ] No

Contact preference: [ ] Home [ ] Cell [ ] Work [ ] Mail [ ] Portal

Pharmacy:_____ Address:_____City_____State_____

Pharmacy Phone:( )_____-_____

****

*For Data Collections Purposes Only; Rural Health, Inc. is required to report the following data for all patients. Rural Health, Inc. reports this information **anonymously** and the information you provide will not affect your payment amount.*

Language spoken (mark all that apply)

[ ]English [ ]Spanish [ ]Other_____ [ ] Decline to Disclose

Interpreter Status Do you require an interpreter? [ ]Yes [ ]No

Race [ ]Asian [ ]American Indian [ ]Black/African-American [ ]Native-Hawaiian [ ]White [ ]More than one race [ ]Other Pacific Islander [ ] Other_____ [ ] Decline to Disclose

Patient Name:_____Date of Birth:_____

Ethnicity [ ]Hispanic or Latino [ ]Not Hispanic or Latino [ ]Declined to Disclose

Marital Status [ ]Unknown [ ]Married [ ]Single [ ]Divorced [ ]Separated [ ]Widowed [ ]Partner

Sexual Orientation [ ]Lesbian gay or homosexual [ ]Straight or heterosexual [ ]Don't know [ ]Bisexual [ ]Something else, please describe_____ [ ]Choose not to disclose

Gender Identity [ ]Identify as a Male [ ]Identify as a Female [ ]Choose not to disclose [ ]Transgender Male/Female-to-Male (FTM) [ ]Transgender Female/Male-to-Female (MTF) [ ]Gender non-conforming (neither exclusively male or female) [ ]Additional gender category/other/please specify_____

Assigned sex at birth [ ]Male [ ]Female [ ]Choose not to disclose [ ]Unknown

Pronouns [ ]he/him [ ]she/her [ ]they/them

Homebound [ ]Yes [ ]No

Homebound if defined as; needing help of another person or medical equipment such as crutches, a walker, or a wheelchair to leave your home, or your doctor believes that your health or illness could get worse if you leave your home.

Agricultural Worker [ ]Yes [ ]No [ ]Patient Declined *Migrant/Seasonal Status [ ] Migrant *(A person/dependent whose principle employment has been in agriculture within The 24 months and has had to establish a temporary home for the purpose of such employment)* [ ] Seasonal *(A person/dependent whose principle employment has been in agriculture on a seasonal basis and has not had to establish a temporary home for the purpose of such employment)*

Homeless Status [ ]Yes [ ]No [ ] Patient Declined [ ]Doubling up [ ]Homeless Shelter [ ]Street [ ]Transitional [ ]Other [ ]Unknown

Veteran Status [ ]Yes [ ]No [ ]Patient Declined

Housing Status [ ]Public Housing [ ]Not in Public Housing [ ]Patient Declined

How did you hear about us? [ ]Advertising [ ]Primary Care Physician [ ] Specialist Physician [ ]Word of Mouth [ ]Patient in the Practice [ ]Hospital [ ]Insurance Company [ ]Existing Patient [ ]Other please specify if other_____

Employer Information

Patient's Employer_____

Address_____

City_____State_____Zip_____

Phone Number_____Occupation:_____

Employment Status: [ ]Full Time [ ]Part Time [ ]Retired [ ]Student [ ]Other

Emergency Contact

Name: _____

Relationship to Patient: _____Emergency Contact Number: ( )_____- _____

Next of Kin

Name:_____Relationship:_____ Phone: ( )_____-_____

Guardian

Last name: _____

First name: _____Middle name, suffix_____

RESPONSIBLE PARTY INFORMATION *(Guarantor) Person to be billed, if other than the patient*

RELATIONSHIP TO PATIENT [ ] Self (skip to next section) [ ] Spouse [ ] Parent [ ] Other

Last Name:_____ First Name:_____

SSN#:_____-_____-_____ Date of Birth: ___/___/____ Gender: [ ]Male [ ]Female

Address (if different from above):_____

City:_____ State: _____Zip Code:_____

Home Phone:( )_____-_____ Cell Phone:( )_____-_____ Work Phone:( )____-_____

Employer:_____ Address_____

City:_____ State:_____ Zip_____

MEDICAL * INSURANCE INFORMATION

[ ] No Insurance [ ]Medicaid/Illinois/MCO [ ]Medicare [ ]Other (Private/Commercial) [ ] Slide Fee Program

- **PRIMARY INSURANCE**

Patient's Relationship to Policy Holder: [ ] Self [ ]Spouse [ ]Child [ ]Other

Plan Name:_____ Policy Number: _____

Group Number:_____ Policy Holder Name:_____

Policy Holder SSN#:_____-_____-_____ Policy Holders Date of Birth:_____

Effective Date (*if known*):_____ Co-pay Amount $_____

Employer:_____ Phone: ( )_____-_____

Employer Address_____ City:_____ State:___Zip:_____

- **SECONDARY INSURANCE**

[ ] None-skip to next section [ ]Medicaid/Illinois/MCO [ ]Medicare [ ]Other (Private/Commercial)

Patient's Relationship to Policy Holder: [ ] Self [ ]Spouse [ ]Child [ ]Other

Plan Name:_____ Policy Number: _____

Group Number:_____ Policy Holder Name:_____

Policy Holder SSN#:_____ -_____-_____ Policy Holders Date of Birth:_____

Employer:_____ Phone: ( )_____-_____

DENTAL * INSURANCE INFORMATION

[ ] No Insurance [ ]Medicaid/Illinois/MCO [ ]Medicare [ ]Other (Private/Commercial) [ ] Slide Fee Program

- **PRIMARY INSURANCE**
  - **Patient's Relationship to Policy Holder**: [ ]Self [ ]Spouse [ ]Child [ ]Other

Plan Name:_____ Policy Number: _____

Group Number:_____ Policy Holder Name:_____

Policy Holder SSN#:_____-_____-_____ Policy Holders Date of Birth:_____

Effective Date (*if known*):_____ Co-pay Amount $_____

Employer:_____ Phone: ( )_____-_____

Employer Address_____ City:_____ State:___Zip:_____

- **SECONDARY INSURANCE**

[ ] None-skip to next section [ ]Medicaid/Illinois/MCO [ ] Medicare [ ] Other (Private/Commercial)

  - **Patient's Relationship to Policy Holder**: [ ]Self [ ]Spouse [ ]Child [ ]Other

Plan Name:_____ Policy Number: _____

Group Number:_____ Policy Holder Name:_____

Policy Holder SSN#:_____-_____-_____ Policy Holders Date of Birth:_____

Employer:_____ Phone: ( )_____-_____

INCOME INFORMATION

State your household income in one of the following categories listed below
[ ] *Choose not to* provide household income

Weekly $_____ Monthly $_____ Yearly/Annual $_____

Income Information – required by federal government

How many family members live in your home?_____

Please tell us about your family income. Find your family size in the far-left column, then go across that same line and circle your annual household income.

Family Size	Level A <100% of Poverty level 1-100%	Level B1 <125% of Poverty level 101-125%	Level B2 <150% of Poverty Level 126 to 150%	Level B3 <175% of Poverty Level 151 to 175%	Level B4 <200% of Poverty Level 176 to 200%	Level C >200% of Poverty Level Over 200%
1	$0 to $14,580	$14,580.01 to $18,225.00	$18,225.01 to $21,870.00	$21,870.01 to $25,515.00	$25,515.01 to $29,160.00	$29,160.01 and over
2	$0 to $19,720	$19,720.01 to $24,650.00	$24,650.01 to $29,580.00	$29,580.01 to $34,510.00	$34,510.01 to $39,440.00	$39,440.01 and over
3	$0 to $24,860	$24,860.01 to $31,075.00	$31,075.01 to $37,290.00	$37,290.01 to $43,505.00	$43,505.01 to $49,720.00	$49,720.01 and over
4	$0 to $30,000	$30,000.01 to $37,500.00	$37,500.01 to $45,000.00	$45,000.01 to $52,500.00	$52,500.01 to $60,000.00	$60,000.01 and over
5	$0 to $35,140	$35,140.01 to $43,925.00	$43,925.01 to $52,710.00	$52,710.01 to $61,495.00	$61,495.01 to $70,280.00	$70,280.01 and over
6	$0 to $40,280	$40,280.01 to $50,350.00	$50,350.01 to $60,420.00	$60,420.01 to $70,490.00	$70,490.01 to $80,560.00	$80,560.01 and over
7	$0 to $45,420	$45,420.01 to $56,775.00	$56,775.01 to $68,130.00	$68,130.01 to $79,485.00	$79,485.01 to $90,840.00	$90,840.01 and over
8	$0 to $50,560	$50,560.01 to $63,200.00	$63,200.01 to $75,840.00	$75,840.01 to $88,480.00	$88,480.01 to $101,120.00	$101,120.01 and over
For a family size greater than 8, for each additional family member, add the following to the upper limit						
9+	$5,140.00	$5,140.01 to $6,425.00	$6,425.01- $7,710.00	$7,710.01 - $8,995.00	$8,995.01 - $10,280.00	$10,280.01 and over

If you circled an income range in column C, we thank you for taking the time to complete this form. Please give this form to the receptionist.
If you circled an income range in column A or B1 or B2 or B3 or B4, you may qualify for discounted medical and dental services.
PLEASE ASK THE RECEPTIONIST FOR A SLIDE FEE APPLICATION

- Signature:

Internal Use: *Patient Service Representative: if a patient's income qualifies for A, B1, B2, B3 or B4, please provide patient with a Slide Fee Application

OFFICE USE ONLY
Qualify for sliding fee discounts? [ ] YES [ ] NO
[ ] <100% [ ] <125% [ ] <150% [ ] <175% [ ] <200%

_____(***please initial***) I hereby authorize the release of my medical information necessary to process claims for the services rendered by Rural Health, Inc. and/or the release of medical information necessary for the application of insurance coverage. A copy of this release will be as valid as the original. I further authorize payment of such services rendered to be made directly to Rural Health, Inc. I understand that I am responsible for any amount not covered by insurance.

_____ (***please initial***) I have received a copy of the Rural Health, Inc. "Notice of Privacy Practices" and "No Show Policy".

_____(***please initial***) I hereby voluntarily consent treatment, tests, and services I permit Rural Health, Inc. and its employees and others involved in my care to treat me in ways they judge to be beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment. I understand that I have the right to withdraw my consent for treatment or tests. I consent to examinations, diagnostic tests, blood tests (including blood tests for any communicable diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), medications, nursing care, and other services or treatment rendered by my provider or other Rural Health, Inc. personnel under the orders or direction of this provider.

_____ _____
Patient or Guardian Signature (please sign) **Date**

_____ _____
RHI Personnel Signature **Date**

PATIENT FINANCIAL & INSURANCE AGREEMENT

PLEASE READ THOROUGHLY AND SIGN BELOW

In consideration of receiving services from Rural Health, Inc, you agree:

1. All services are provided to you with the understanding that you are responsible for the charges regardless of your insurance coverage. If you would like to know the charge of a service, please inquire prior to treatment. Please be aware that not all services are a covered benefit with different insurance companies. You are responsible for knowing what services are or are not covered. **KNOW YOUR BENEFITS.**

2. At check-in, we will collect your co-pay, deductible, and payment for uncovered services as well as the patient's portion as determined by insurance or sliding fee scale. We accept cash, check, and credit card of Master Card, Visa, and Discover.

3. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. **It is the patient's responsibility to inform our office immediately of insurance coverage or insurance company changes**.

4. You are responsible for knowing if a referral is required. Make sure you know what providers are in your plan, what facilities are covered and what ancillary services you must use. (Such as laboratory, hospitals, etc.) If we can be of assistance, please let us know.

5. We will bill your insurance company as a courtesy, but you are still ultimately responsible for payment of all services you receive. If your insurance company does not respond within 30 days we will follow up with an inquiry on your behalf. If, however, your insurance does not respond within 60 days of claim submission, a statement will be sent to you. You should call your insurance company to question why the claim is not paid. Our office will assist you only after you have contacted your insurance company.

6. If your medical claim has not been paid and your insurance company has not resolved your dispute, you may register a complaint with the Illinois Department of Commerce and Insurance. Our office will do everything we can to assist you; however, you must understand you cannot delay payment while you are awaiting the outcome of your complaint.

7. Any unpaid charges over 90 days old will be sent to an outside collection agency with an additional agency fee. **You are responsible for any collection fees, legal fees, or court costs incurred in the collection process**. This agency will report your failure to pay to the THREE (3) national credit reporting agencies.

8. Returned checks are subject to a $25.00 return check fee.

We do understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems so that we can assist you in the management of your account.

I authorize the Rural Health Inc., to examine, evaluate, and treat me, and/or my child, or ward. I authorize the RHI to release any\all clinical information necessary in order to submit my insurance claims to my insurance companies. I also request that my insurance companies pay benefits directly to the RHI for services rendered. I understand that the RHI will refund any overpayments on my account, in a timely manner.

Your signature below forms a binding agreement between the RHI (the provider of service) and the Patient who is receiving services or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of any charges

_____**Print Name of Patient (please print your name)**

_____**Patient or Guardian Signature (please sign your name)**

_____**Date**

_____**RHI Staff Signature**

_____**Date**