RURAL HEALTH, Inc.
We specialize in you

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_____

Patient Name:_____**Date of Birth**_____

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_____

Patient Name:_____Date of Birth_____

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

Income Information – required by federal government to better serve our community

This is not an application for the Sliding Fee Program

State your household income in one of the following categories listed below

[ ] Choose not to provide household income

2025

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 Estimated 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 $15,650	$15,650.01 to $19,562.50	$19,562.51 to $23,475.00	$23,475.01 to $27,387.50	$27,387.51 to $31,300.00	$30,300.01 and over
2	$0 to $21,150	$21,150.01 to $26,437.50	$26,437.51 to $31,725.00	$31,725.01 to $37,012.50	$37,012.51 to $42,300.00	$42,300.01 and over
3	$0 to $26,650	$26,650.01 to $33,312.50	$33,312.51 to $39,975.00	$39,975.01 to $46,637.50	$46,637.51 to $53,300.00	$53,300.01 and over
4	$0 to $32,150	$32,150.01 to $40,187.50	$40,187.51 to $48,225.00	$48,225.01 to $56,262.50	$56,262.51 to $64,300.00	$64,300.01 and over
5	$0 to $37,650	$37,650.01 to $47,062.50	$47,062.51 to $56,475.00	$56,475.01 to $65,887.50	$65,887.51 to $75,300.00	$75,300.01 and over
6	$0 to $43,150	$43,150.01 to $53,937.50	$53,937.51 to $64,725.00	$64,725.01 to $75,512.50	$75,512.51 to $86,300.00	$86,300.01 and over
7	$0 to $48,650	$48,650.01 to $60,812.50	$60,812.51 to $72,975.00	$72,975.01 to $85,137.50	$85,137.51 to $97,300.00	$97,300.01 and over
8	$0 to $54,150	$54,150.01 to $67,687.50	$67,687.51 to $81,225.00	$81,225.01 to $94,762.50	$94,762.51 to $108,300.00	$108,300.01 and over
For a family size greater than 8, for each additional family member, add the following to the upper limit						
9+	$5,500.00	$5,500.01 to $6,875.00	$6,875.01- $8,250.00	$8,250.01 - $9,625.00	$9,625.01 - $11,000.00	$11,000.01 and over

If an income is circled in the Column C range, we thank you for taking the time to complete this form.
Please give this form to the receptionist.

If an income is circled in the Column A or B1 or B2 or B3 or B4,
you may qualify for discounted medical and dental services.

PLEASE ASK RECEPTIONIST FOR A SLIDE FEE APPLICATION

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

APPLICATION PROVIDED TO PATIENT _____

Patient Declined to Apply_____

OFFICE USE ONLY

Qualify for sliding fee discounts? [ ] YES [ ] NO

[ ] <100% [ ] <125% [ ] <150% [ ] <175% [ ] <200%

Patient Name:_____Date of Birth:_____

____ I received the Sliding Fee Application

____ I declined the Sliding Fee Application

_____ _____

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

_____ _____

RHI Personnel Signature Date

PATIENT FINANCIAL & INSURANCE CONSENT TO TREAT – PRIVACY NOTICE – RELEASE OF MEDICAL INFORMATION PERTAINING TO CLAIMS

Patient Name: _____Date of Birth:_____

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**.

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.

_____***(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.

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

_____ _____

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

_____ _____

RHI Personnel Signature **Date**

created: 01/12/2024 revised: 11-04-2024 lah

OB/GYN • MEDICAL • DENTAL • PSYCHIATRY

RURAL HEALTH, Inc.

We specialize in you

CONSENT FORM FOR MINORS

I _____ authorize the following people to
(legal guardian)

accompany _____for treatment, including but not
(minor)

limited to fillings and extractions, and discuss further treatment.

1. _____ Relationship to Patient _____

2. _____ Relationship to Patient _____

3. _____ Relationship to Patient _____

4. _____ Relationship to Patient _____

5. _____ Relationship to Patient _____

_____ (Photo ID Required)
Name (printed)

_____ _____
Signature Date

_____
Relationship to Patient

A PHOTO ID IS REQUIRED FOR EACH AUTHORIZED PERSON AT THE TIME OF VISIT

RURAL HEALTH, INC. DENTAL CLINIC

Dental Contact Preference Form

☐ **Phone**

- □ Home # _____
- □ Cell # _____

☐ **Text Message (text message charges may apply)**

Please list what number we should send text messages to:

_____

☐ **Email**

Please list your current email address:

_____

Please check ***at least*** one contact method above.

Signature:

_____

Relationship to Patient:

_____

Date Signed:

_____

THANK YOU.

RURAL HEALTH, Inc.
We specialize in you

Dental/Medical History

Patient Name:_____Date of Birth:_____

Why are you here today?_____

Are you having pain or discomfort at this time? _____ □ Yes □ No

If yes, what type and where? _____

Have you been under the care of a medical doctor during the past two years? □ Yes □ No

Medical Doctor's Name: _____

Address: _____

Telephone Number: _____

Are you taking any medication, drugs, or pills? □ Yes □ No

If yes, please list:_____

Are you taking any prescription blood thinners (Coumadin, Warfarin, Plavix, etc.)? □ Yes □ No

If yes, please list: _____

Are you taking or have you ever taken any prescription weight loss drugs, such as Fen-Phen, etc.? □ Yes □ No

If yes, please list:_____

Are you taking or have you ever taken any prescription medications for an osteoporosis condition (or preventative for this condition) such as the bisphosonates Fosamax or Boniva, or any others? □ Yes □ No

If yes, please list: _____

Are you aware of being allergic to or have you ever reacted badly to any medication or substance? □ Yes □ No

If yes, please list:_____

Have you ever been diagnosed with or had Lupus or any other autoimmune type diseases? □ Yes □ No

If yes, please list: _____

Do you use two or more pillows to sleep? □ Yes □ No

Do you use tobacco products (smoke or chew tobacco)? □ Yes □ No

Do you drink alcoholic beverages? □ Yes □ No

Are you pregnant? □ Does not apply □ Yes □ No

If yes, when are you due? _____

Are you nursing? □ Does not apply □ Yes □ No

Are you taking birth control pills? □ Does not apply □ Yes □ No

Have you ever had (mark yes or no)?

Heart Disease or Attack	□ Yes	□ No	Artificial Joints (Hip, Knee, Etc.)	□ Yes	□ No	Dental Phobia	□ Yes	□ No
Heart Failure	□ Yes	□ No	Stroke	□ Yes	□ No	Arteriosclerosis	□ Yes	□ No
Angina Pectoris	□ Yes	□ No	Venereal Disease	□ Yes	□ No	Ulcers	□ Yes	□ No
Congenital Heart Disease	□ Yes	□ No	Heart Murmur	□ Yes	□ No	AIDS	□ Yes	□ No
Cancer	□ Yes	□ No	Glaucoma	□ Yes	□ No	Blood Transfusion	□ Yes	□ No
Diabetes	□ Yes	□ No	Cortisone Medication	□ Yes	□ No	Cold Sores/Fever Blisters/Herpes	□ Yes	□ No
HIV Positive	□ Yes	□ No	Hay Fever	□ Yes	□ No	Artificial Heart Valve	□ Yes	□ No
High Blood Pressure	□ Yes	□ No	Anemia	□ Yes	□ No	Heart Pacemaker	□ Yes	□ No
Mitral Valve Prolapse	□ Yes	□ No	Heart Surgery	□ Yes	□ No	Memory Loss	□ Yes	□ No
Emphysema	□ Yes	□ No	Hepatitis B (serum)	□ Yes	□ No	Asthma	□ Yes	□ No
Chronic Cough	□ Yes	□ No	Rheumatic Fever	□ Yes	□ No	Blood Thinners	□ Yes	□ No
Tuberculosis	□ Yes	□ No	Epilepsy or Seizures	□ Yes	□ No	Fainting or Dizzy Spells	□ Yes	□ No
Liver Disease	□ Yes	□ No	Pain in Jaw Joints	□ Yes	□ No	Chemotherapy	□ Yes	□ No
Arthritis	□ Yes	□ No	Radiation Therapy	□ Yes	□ No	Drug Addiction	□ Yes	□ No
Allergies or Hives	□ Yes	□ No	Thyroid Problems	□ Yes	□ No	Alcohol Abuse	□ Yes	□ No
Sinus Trouble	□ Yes	□ No	Hepatitis C	□ Yes	□ No	Psychiatric Treatment	□ Yes	□ No
Surgeries (Please List type and When):								

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully.

Patient or Guardian Signature: _____

Date: _____

RURAL HEALTH, INC. DENTAL CLINIC
NO SHOW POLICY

Dear Patient, Parent, or Guardian of:

Our No Show Policy is strict in order to provide good services to patients. If you have an appointment, you must call to confirm or cancel your appointment within 24 hours (one business day) or your appointment may no longer be reserved for you. Appointment cancellations with less than 24 hours (one business day) notice, are considered to be a missed appointment. Dismissals for continued no shows for new patient appointments will be left to the discretion of the dentist.

For returning patients, the dental clinic will send a letter the first time an appointment is missed without the patient or care giver giving 24 hours notice. For the second missed appointment a warning will be sent. The third missed appointment may result in dismissal from the dental clinic.

Thank you for your cooperation,

Patient Name: _____ DOB: _____

Signature: _____

Relationship to Patient: _____

Date Signed: _____

RURAL HEALTH, Inc.
We specialize in you

No Show Policy

We are committed to provide quality care at Rural Health, Inc.

An appointment is time allotted for you to meet with a provider for needed services.

If you are unable to keep your appointment as scheduled, we ask that you please call at least 24 hours in advance and reschedule or cancel. We realize that emergency situations can arise. If this happens, please call as soon as possible. If you can call ahead and cancel/reschedule your appointment, this can be given to another patient in need of an appointment.

In an effort to provide appointments for all patients that need them and to decrease the number of No Show appointments, Rural Health, Inc. is implementing a No Show Policy. A No Show is defined as a failure to show up for an appointment prior to or within 15 minutes after your scheduled time without calling to cancel or reschedule prior to the appointment time.

No Shows will be documented in your medical record. If you miss three (3) appointments in a row or three (3) appointments in a six (6) month period without calling before the appointment to cancel/reschedule, you may be discharged from Rural Health, Inc. services.

RURAL HEALTH, Inc.
We specialize in you

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

Starting April 13, 2003, Rural Health, Inc. (RHI) is required to maintain the privacy of your protected health information as a result of the Health Insurance Portability and Accountability Act (HIPAA). Your "protected health information" means health information, including demographic information (for example, your name, address, and phone number) collected from you and created or received by the physician, another health care provider, a health plan, or a health care clearinghouse.

RHI must follow this Notice until it is replaced. This notice explains how RHI can use or share your health information. It also explains your rights. RHI reserves the right to change the terms of this Notice at any time. If RHI changes this Notice, a copy of the current Notice will be posted in a prominent location. We will provide you with any revised notice of Privacy Practices when you ask. To get a copy of RHI's Notice of Privacy Practices, you may access our website at www.ruralhealthinc.org, call any office and request a revised copy be sent to you in the mail, or you may ask for one at the time of your next appointment.

Purposes for which RHI may use or disclose your personal health information without your authorization:

- Health Care Treatment Purposes, For example, RHI may disclose our personal health information to your doctor, at the doctor's request, for treatment by your doctor.

- Payment. For example, RHI may use or disclose your personal health information to provide eligibility information to your doctor when you receive treatment, to pay for claims for covered health care services, or to recover costs from other medical insurance.

- Health Care Operations. For example, RHI or its contractors may use or disclose your personal health information (1) to conduct quality assessment and improvement activities; (2) to review applications for services: (3) to engage in care coordination or case management: (4) to manage, plan or develop RHI's services and budget: (5) to coordinate services with another public benefit program: or (6) to cooperate with state and federal auditors.

- Health Services. RHI or its contractors may contact you, for example to give you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

- As Required by Law. For example, RHI is required by law to allow the United States Department of Health and Human Services to audit RHI records. RHI may disclose your personal health information necessary to comply with workers' compensation or other laws. RHI may also be required to disclose personal health information about abuse, neglect, or domestic violence to governmental or social services agencies.

- For other Reasons:
  - To comply with legal proceedings, such as a court or administrative order or subpoena.
  - To law enforcement officials or to correctional institutions for limited law enforcement and health and safety purposes.
  - With your written authorization, to a family member, friend or other person, to help you with your health care or payment for your health care.
  - To your personal representative appointed by you or designated by law.
  - For research purposes in limited circumstances and where the information will be protected by the researchers
  - To a coroner, medical examiner, or funeral director to identify a deceased person or to arrange payment benefits.
  - To an organ procurement organization, in limited circumstances.
  - To avert a serious threat to your health or safety or health or safety of others.
  - To a governmental agency authorized to oversee government health care programs.
  - To federal officials for lawful national security purposes.
  - To public health authorities for public health purposes.

- To appropriate military authorities, if you are a member of the armed forces.

Uses and disclosures with your permission. RHI will not use or disclose your personal health information for any other purposes unless you give RHI your written authorization to do so. In most cases, you may revoke your written authorization at any time, unless RHI has relied upon your authorization for a continuing disclosure, for example, for a research study. Your revocation will be effective from the date RHI receives the revocation forward, for all your personal health information that RHI maintains. Authorization and Revocation forms are available at all RHI offices.

Your Rights. You may make a written request to RHI to do one or more of the following concerning your personal health information that RHI maintains:

- To put additional restrictions on RHI's use and disclosure of your personal health information. RHI does not have to agree with your request.
- To have RHI communicate with you in confidence about your personal health information by a different means or at a different location than RHIS is currently doing. Your request must be in writing specifying the alternative means or location to communicate with you.
- To see and get copies of your personal health information, except for psychotherapy notes or information for use in a civil, criminal or administrative action or proceeding (this is a federal law). You may be charged a fee for copies.
- To correct your personal health information. In some cased, RHI does not have to agree to your request.
- To receive a list of disclosures of your personal health information that RHI and its contractors made for certain purposes for the last six years, but not for disclosures made before April 14, 2003.

If you want to exercise any of these rights described in this Notice, please contact the RHI Privacy Officer at the address below. RHI will give you the necessary information and forms for you to complete and return to RHI.

Complaints. If you believe your privacy rights have been violated by RHI, you have the right to complain to RHI or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with RHI at the address where you receive services. RHI will not retaliate against you if you choose to file a complaint with RHI or with the U.S. Department of Health and Human Services.

Privacy Officer. To request additional copies of this Notice or to receive more information about RHI's privacy practices, your rights or to file a complaint, please contact the Privacy Officer at the following address:

RHI Privacy Office
Rural Health, Inc.
513 North Main Street
Anna, Illinois 62906
Phone 618-833-4471

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.
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.***