NorthShore Health Centers

Dental Registration Form - Adult

PATIENT INFORMATION			**Today's Date: ___ / ___ / _____**
Last Name	**First**		**M.I.**
Date of Birth ___ / ___ / _____	**Social Security No.**	- -	
Street Address		**Apartment/Unit#**	
Mailing Address			
City	**State**	**Zip Code**	**Township**
Home Phone	**Cell Phone**	**Email**	

By providing my email address above, I hereby allow NorthShore Health Centers to contact me by email with e-newsletters, wellness reminders, health news, and updates regarding health-related services provided by NorthShore Health Centers.

PARENT OR GUARDIAN #1			
Last Name	**First**	**M.I.**	**Relationship to Patient**
Address			**Apartment/Unit#**
City	**State**		**Zip Code**

This site is a **Federally Qualified Health Center (FQHC)**, which means we receive a federal grant that allows us to provide a discounted fee program to our patients who qualify. We are required to provide certain information to the Bureau of Primary Health Care each year regarding all of our patients. The only reason this information is collected is for reporting purposes and we respect that this is personal and confidential information. Your help is much appreciated.

Gender Identity:	☐ Male ☐ Female ☐ Gender Queer ☐ Other ☐ Declined ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female	
Housing Status:	☐ Doubling Up ☐ Homeless ☐ Not Homeless ☐ Shelter ☐ Street ☐ Transitional ☐ Unknown	**Veteran Status:** ☐ Yes ☐ No
Sexual Orientation:	☐ Straight or Heterosexual ☐ Lesbian, Gay, or Homosexual ☐ Bisexual ☐ Something Else ☐ Don't Know ☐ Declined	
Race:	☐ American Indian/Native Alaskan ☐ Asian ☐ Black/African American ☐ More than one race ☐Native Hawaiian ☐ Other Pacific Islander ☐ Refused ☐ White	
Ethnicity:	Are you Hispanic/Latino? ☐ Yes ☐ No ☐ Refused	
Primary Language	☐ English ☐ Spanish ☐ Other _____	**Do you need an interpreter?** ☐ Yes ☐ No
Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Widowed	**Employment Status:** ☐ Full Time ☐ Part Time ☐ Self-Employed ☐ Retired ☐ Seasonal ☐ Migrant ☐ Unemployed
Annual Household Income	☐ $0 – 10,900 ☐ $10,901 – 18,100 ☐ $18,101 – 27,225 ☐ $27,226 – 40,099 ☐ $40,100 – 55,000 ☐ $55,001 – 65,000 ☐ $65,000+	**Number in Household**
Primary Care Provider:	**Preferred Pharmacy:**	**Pharmacy Address:**

EMERGENCY CONTACT		
Name	**Relationship**	**Telephone**

CURRENT HEALTHCARE PROVIDERS		
Do you have a previous Medical Care Provider?	☐ Yes ☐ No	*If yes – please list:*
Do you have a Dentist?	☐ Yes ☐ No	*If yes – please list:*

HOW DID YOU HEAR ABOUT US?

☐ Family or Friend ☐ Staff ☐ Billboard ☐ Online/Internet ☐ TV ☐ Yellow Pages ☐ Newspaper
☐ Flyer/Brochure ☐ Direct Mail ☐ Community Event ☐ Doctor/Hospital
☐ Other _____ (Please Specify)

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MEDICAL HISTORY (please check those that apply):

- ☐ AIDS/HIV
- ☐ Allergies
  - ☐ Anesthetic
  - ☐ Epinephrine
  - ☐ Codeine
  - ☐ Latex
  - ☐ Penicillin
  - ☐ Sulfa
  - ☐ Other: _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints – (specify)
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis – Type _____
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Organ Transplant
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Surgeries (Specify)
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Other (specify)

SOCIAL HISTORY (please check those that apply):

Tobacco Use

Current Smoker: ☐ Yes ☐ No

Cigarettes: ☐ Never ☐ Quit Date: _____

Number of packs/day _____ Number of Years _____

Other Tobacco

☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use

Do you drink alcohol? ☐ Yes ☐ No

Number of drinks/week _____

Drug Use

Do you currently or have you in the past used any recreational drugs? ☐ Yes ☐ No

1. Have you ever had any complications following dental treatment? ☐ Yes ☐ No

   If yes, please explain: _____
2. Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

   If yes, please explain: _____
3. Are you now under the care of a physician? ☐ Yes ☐ No

   If yes, please explain: _____

   Name of Physician: _____ Phone: _____
4. Do you have any health problems that need further clarification? ☐ Yes ☐ No

   If yes, please explain: _____
5. Are you currently on any blood thinners? ☐ Yes ☐ No
6. Please list any medications you are currently taking: _____
7. WOMEN: Are you pregnant or think you may be pregnant? ☐ Yes ☐ No

History Review

Dentist Signature: _____ **Date:** _____

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INSURANCE INFORMATION			
Primary Insurance:	**ID:**	**Group:**	
Insurance Phone:	**Subscriber Name:**	**Date of Birth:** ___ / ___ / _____	
Social Security Number - -	**Employer**		
Secondary Insurance:	**ID:**	**Group:**	
Insurance Phone:	**Subscriber Name:**	**Date of Birth:**	___ / ___ / _____
Social Security Number - -	**Employer**		

Patient Responsibilities

It is our goal at NorthShore Health Centers to provide you with quality health care. We want to work together for your health. To give you the best care possible, your cooperation is expected and appreciated.

As a NorthShore patient, you are responsible for:

Your Personal Interactions

- Be considerate of other patients and staff and for assisting in the control of noise.
- Be respectful of the property of other patients, staff, and of NorthShore Health Centers.
- Treat all staff and other patients with respect.
- Do not make threatening or offensive statements at NorthShore Health Center facilities.
- Do not engage in any act of physical violence or other threatening or inappropriate behavior at NorthShore Health Center facilities.

Active Engagement in Your Care

- Participate in care decisions in a respectful, courteous manner and follow the plan of care agreed upon. If you have any questions, just ask. If you cannot comply with your care plan, communicate this with staff.
- Give full, honest information on all forms and in conversation. Report any changes to your general condition, symptoms, allergies, etc. Bring a list of your medications with you to your appointments.
- Show up for your appointments on time and provide 24 hour notice to cancel or reschedule. If you have two no-show appointments, you will no longer be able to schedule an appointment. You may walk in and wait until an opening becomes available.

At NorthShore Health Centers, we always strive to make your experience as pleasant and positive as possible.

Patient Acknowledgement of Financial Obligation

NorthShore Health Centers is a Federally Qualified Health Center (FQHC) that is subject to Section 330 of the Public Health Service Act. Section 330 specifies that Health Centers must assure that no patient is denied services due to their inability to pay for such services. It also requires Health Centers to adopt written policies and procedures to maximize collections and reimbursement for their costs in providing health services. We are not a "Free Clinic", but are able to offer reasonable fees once individual situations are reviewed.

As a NorthShore patient, you are responsible for:

- Contributing to the cost of your care and treatment as my health insurance coverage requires and based on your ability to pay as determined by NorthShore policies;
- Providing NorthShore Health Centers with the information it needs to receive reimbursement for the treatment or services that it provides;
- Requesting consideration for discounted fees under NorthShore's Sliding Fee Scale based on your level of income, and providing documentation to support eligibility for discounted fees that may be requested;
- Paying a $25.00 charge if you do not show for your appointment and you do not call within 24 hours to cancel or reschedule;
- Paying your fees for medical, behavioral health, or dental services received at NorthShore in full at the time of service;

If payment is not received within 60 days, your account will be turned over to our collection agency. **Patient agrees to pay all costs incurred with collection of any past due account, including a flat fee of $25 and a minimum of $125 in legal fees including court cost, and attorney fees.**

Assignment and Release

I hereby consent to all treatment deemed necessary by the medical staff of NorthShore Health Centers. I authorize the release of any information necessary to process claims or any other collection process. I request that any money due to me for medical benefit be assigned to NorthShore Health Centers. I realize that I am responsible for any and all difference. I agree to pay my fees at time of service and all fees associated with the collection process including but not limited to, attorney fees and court cost if my account becomes delinquent. I have read through the above policies and understand the responsibilities I have as a NorthShore patient.

Patient Signature: _____ Date: _____

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DISCLOSURE OF PROTECTED HEALTH INFORMATION

THIS FORM IS TO PROTECT YOUR CONSENT TO USE OR DISCLOSE YOUR PROTECTD HEALTH INFORMATION

1. **INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING THE CONSENT**
   I give my consent to use or disclose my protected health information as described below. I give this consent voluntarily.

   Individual Patient's Name:
   _____

   Your Address:
   _____

   Your Telephone Number:
   _____

   Your Date of Birth: _____ Last 4-digits of your Social Security Number _____

Including Parent Proxy (Patient Portal)

Name the people and/or organization which you are giving consent for them to receive and use your protected health information, along with their relationship to you.

_____

_____

INDIVIDUAL PATIENT'S CONSENT

2. **ENDING THIS CONSENT**
   This consent will expire one year after this form has been completed by the patient or the patient's legal representative. To end this consent prior to the end of one year the patient or the patient's legal representative will need to notify NorthShore Health Centers in writing.
3. **CHANGING YOUR MIND ABOUT THIS CONSENT**
   I understand that I may revoke this consent at any time by giving written notice to the medical records manager at NorthShore Health Center's. However, I understand that I may not revoke this consent for any actions taken before the receipt of my written notice to revoke this consent. In addition, I understand that if I am giving consent as a condition of obtaining insurance coverage, and I revoke this consent, the insurance company has right to contest my claims under the insurance policy.
4. **INDIVIDUAL PATIENT'S SIGNATURE**
   I have had the chance to read the content of this consent form and I agree with all statements made in this consent. I understand that, by signing this form, I am confirming my consent for use and/or disclosure of the protected health information described in this form with the people and/or the organizations named in this form.

Signature: _____ Date: _____

If this consent form is signed by a personal representative for the individual patient:
Personal Representative's Name: _____
Print Name

_____
Signature

Relationship to Individual Patient: _____

YOU HAVE A RIGHT TO HAVE A COPY OF THIS AFTER YOU SIGN IT

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand NorthShore Health Center's *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that NorthShore Health Center may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy NorthShore Health Center's *Notice of Privacy Practices* by submitting a request in writing for a current copy of NorthShore Health Center's *Notice of Privacy Practices*.

_____
Printed Patient Name

_____ _____
Patient Signature Date

If completed by patient's personal representative, please print name and sign below.

_____ _____
Printed Patient Personal Representative Name Relationship to Patient

_____ _____
Patient Personal Representative Signature Date

For NorthShore Health Center Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

NorthShore Health Center made a good faith effort to obtain patient's written acknowledgement of the *Notice of Privacy Practices* but was unable to do so for the reasons documented below:

- ☐ Patient or patient's personal representative refused to sign
- ☐ Patient or patient's personal representative unable to sign
- ☐ Other_____

_____
Printed Employee Name

_____ _____
Employee Signature Date

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Notice of Privacy Practice Guidelines	
HP 1.2 Attachment A	
Effective Date: May 2016	Review: Annually

PLEASE REVIEW IT CAREFULLY.

1. Introduction

NorthShore Health Center is required by law to maintain the privacy of your health information and to provide individuals with notice of its legal duties and privacy practices with respect to health information. NorthShore Health Center is required to abide by the terms of the Notice currently in effect. NorthShore Health Center reserves the right to change the terms of its notice and to make the new notice provisions effective for all PHI that it maintains.

This Notice of Privacy Practices and Policies outlines our practices, policies and legal duties to maintain confidentiality and protect against prohibited disclosure of protected health information ("PHI") under the privacy regulations mandated by the Health Insurance Portability and Accountability Act ("HIPAA") and further expanded by the Health Information Technology for Economic Clinical Health Act ("HITECH").

PHI includes your demographic information such as name, address, telephone number, and family; past, present, or future information about your physical or mental health or condition; and information about the medical services provided to you, including payment information, if any of that information may be used to identify you. Your PHI may be maintained by us electronically and/or on paper.

This Notice describes uses and disclosures of PHI to which you have consented, that you may be asked to authorize in the future, and that are permitted or required by state or federal law. Also, it advises you of your rights to access and control your PHI.

We may amend this Notice of Privacy Practices and Policies periodically. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices or you may obtain a copy by accessing our website at www.northshorehealth.org by calling the office, 219-763-8112 and requesting that a revised copy be sent to you in the mail, or asking for one at the time of your next appointment.

We regard the safeguarding of your PHI as an important duty. The elements of this Notice and any authorizations you may sign are required by state and federal law for your protection and to ensure your informed consent to the use and disclosure of PHI necessary to support your relationship with NorthShore Health Center.

If you have any questions about NorthShore Health Center's Notice of Privacy Practices and Policies, please contact the Tasha Kozar at 219.763.8112 at Ext 2401.

2. Safeguarding PHI within our Practice

We have in place appropriate administrative, technical, and physical safeguards to protect and to secure the privacy and security of your PHI. We orient our staff to the regulations and policies developed to protect the privacy of your PHI, and review their obligation to maintain privacy and security annually. We hold medical records in a secure area within our practice, and our electronic medical record system is monitored and updated to address security risks in compliance with the HIPAA Security Rule. Only staff members who have a legitimate "need to know" are permitted access to your medical records and other PHI. Our staff understands the legal and ethical obligation to protect your PHI and that a violation of this Notice of Privacy Practices and Policies may result in disciplinary action in accordance with our Human Resource policies.

3. Uses and Disclosures of PHI

As part of our registration materials, we will request your written consent for our practice to use and disclose your PHI for the following types of activities:

- **Treatment.** Treatment means the provision, coordination, or management of your health care and related services by NorthShore Health Center and health care providers involved in your care. Students and/ or interns may be a member of the health care team. It includes the coordination or management of health care by a provider with a third party insurance carrier, communication with lab or imaging providers for test results, consultation between our clinical staff and other health care providers relating to your care, or our referral of you to a specialist physician or facility.
- **Payment.** Payment means our activities to obtain reimbursement for the medical services provided to you, including billing, claims management, and collection activities. Payment also may include your insurance carrier's efforts in determining eligibility, claims processing, assessing medical necessity, and utilization review. Payment may also include activities carried out on our behalf by one or more of our collection agencies or agents in order to secure payment on delinquent bills.

- **Health Care Operations.** Health care operations mean the legitimate business activities of our practice. These activities may include quality assessment, improvement and systems troubleshooting activities; fraud & abuse compliance; business planning & development; information systems troubleshooting; and business management & general administrative activities. These can also include contacting you through telephone or other electronic means to remind you of appointments, or using a translation service if we need to communicate with you in person, or on the telephone, in a language other than English. When we involve third parties in our business activities, we will have them sign a Business Associate Agreement obligating them to safeguard your PHI according to the same legal standards we follow.

4. Electronic Exchange of PHI

We may transfer your PHI to other treating health care providers electronically. We may also transmit your information to your insurance carrier electronically.

5. Uses and Disclosures of PHI Based Upon Your Written Authorization

Other uses and disclosures of your PHI will be made only with your specific written authorization. This allows you to request that NorthShore Health Center disclose limited PHI to specified individuals or companies for a defined purpose and timeframe. For example, you may wish to authorize disclosures to individuals who are not involved in treatment, payment, or health care operations, such as a family member or a school physical education program. If you wish us to make disclosures in these situations, we will ask you to sign an authorization allowing us to disclose this PHI to the designated parties.

6. Uses and Disclosures of PHI Permitted or Required by Law

In some circumstances, we may be legally bound to use or disclose your PHI without your consent or authorization. State and federal privacy law permit or require such use or disclosure regardless of your consent or authorization in certain situations, including, but not limited to:

- **Emergencies.** If you are incapacitated and require emergency medical treatment, we will use and disclose your PHI to ensure you receive the necessary medical services. We will attempt to obtain your consent as soon as practical following your treatment.
- **Others Involved in Your Healthcare:** Upon your verbal authorization, we may disclose to a family member, close friend or other person you designate only that PHI that directly relates to that individual's involvement in your healthcare and treatment. We may also need to use PHI to notify a family member, personal representative or someone else responsible for your care of your location and general condition.
- **Communication barriers.** If we try but cannot obtain your consent to use or disclose your PHI because of substantial communication barriers and your physician, using his or her professional judgment, infers that you consent to the use or disclosure, or the physician determines that a limited disclosure is in your best interests, NorthShore Health Center may permit the use or disclosure.
- **Required by Law:** We may disclose your PHI to the extent that its use or disclosure is required by law. This disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.
- **Public Health/Regulatory Activities:** We may disclose your PHI to an authorized public health authority to prevent or control disease, injury, or disability or to comply with state child or adult abuse or neglect law. We are obligated to report suspicion of abuse and neglect to the appropriate regulatory agency.
- **Food and Drug Administration:** We may disclose your PHI to a person or company as required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations as well as to track product usage, enable product recalls, make repairs or replacements or to conduct post-marketing surveillance.
- **Health oversight activities.** We may disclose your PHI to a health oversight agency for audits, investigations, inspections, and other activities necessary for the appropriate oversight of the health care system and government benefit programs such as Medicare and Medicaid.
- **Judicial and administrative proceedings.** We may only disclose your PHI in the course of any judicial or administrative proceeding in response to a court order expressly directing disclosure, or in accordance with specific statutory obligation compelling us to do so, or with your permission.
- **Law enforcement activities.** In accordance with Indiana state law, we may not disclose your PHI to a law enforcement officer for law enforcement purposes without court order, statutory obligation or patient authorization.
- **Coroners, medical examiners, funeral directors and organ donation organizations:** We may disclose your PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other

lawful duties. We also may disclose your PHI to enable a funeral director to carry out his or her lawful duties. PHI may also be disclosed to organ banks for cadaveric organ, eye, bone, tissue and other donation purposes.

- **Research.** We may disclose your PHI for certain medical or scientific research where approved by an institutional review board and where the researchers have a protocol to ensure the privacy of your PHI.
- **Serious threats to health or safety.** We may disclose your PHI to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **Military activity & national security.** We may disclose the PHI of members of the armed forces for activities deemed necessary by appropriate military command authorities to assure proper execution of the military mission. We also may disclose your PHI to certain federal officials for lawful intelligence and other national security activities.
- **Worker's Compensation:** We may disclose your PHI as authorized to comply with worker's compensation law.
- **Inmates of a Correctional Facility:** We may use or disclose PHI if you are an inmate of a correctional facility and our practice created or received your PHI in the course of providing care to you while in custody.
- **US Department of Health and Human Services:** We must disclose your PHI to you upon request and to the Secretary of the United States Department of Health & Human Services to investigate or determine our compliance with the privacy laws.
- **Disaster Relief Activities:** We may disclose your PHI to local, state or federal agencies engaged in disaster relief and to private disaster relief assistance organizations (such as the Red Cross if authorized to assist in disaster relief efforts).

7. Your Rights Regarding PHI

- **Right to request restriction of uses and disclosures.** You have the right to request that we not use or disclose any part of your PHI unless it is a use or disclosure required by law. Please advise us of the specific PHI you wish restricted and the individual(s) who should not receive the restricted PHI.
  We are not required to agree to your restriction request, with one exception*, but if we do agree to the request, we will not use or disclose the restricted PHI unless it is necessary for emergency treatment. In that case, we will ask that the recipient not further use or disclose the restricted PHI. You may request restrictions and identify the parties to be restricted in writing to the Director of Medical Information.

  *If you request that access be restricted to your PHI for services for which you have fully paid yourself out-of-pocket and not be made available to your insurance carrier, we must agree to your request.
- **Right of access to PHI.** You have the right to inspect and obtain a copy of your PHI upon your written request. Under very limited circumstances, we may deny access to your medical records. To request access to your medical record call NorthShore Health Center during business hours. We will respond to your request as soon as possible, but no later than 30 days from the date of your request. If access is denied you will receive a denial letter within 30 days. There is an appeals process. We have the right to charge a reasonable fee for providing copies of your PHI.
- **Right to confidential communications.** You have the right to reasonable accommodation of a request to receive communication of PHI by alternative means or at alternative locations. For example, you may wish your bill to be sent to an address other than your home. Please make your request in writing to NorthShore Health Center. We will not require an explanation of your reasons for the request, and will attempt to comply with reasonable requests, but you will be required to assume any costs associated with forwarding your PHI by alternate means. ***Please Note: Personal Health Information will be discussed in the exam room. If there are others that accompany you into the exam room, it is <u>your</u> responsibility to ask them to step out of the exam room if you do not want them to be present during your communication with the provider.***
- **Right to amend PHI.** You have the right to request that we amend your PHI. Your request must be made in writing to us. We will respond to your request as soon as possible, but no later than 60 days from the date of your request. If we deny your request for amendment, you have the right to submit a written statement disagreeing with the denial; NorthShore Health Center also has the right to submit a rebuttal statement. A record of any disagreement about amendment will become part of your medical record and may be included in subsequent disclosures of your PHI.
- **Right to accounting of disclosures.** Subject to certain limitations, you have the right to a written accounting of disclosures by us of your PHI for not more than 6 years prior to the date of your request. Your right to an accounting applies to disclosures other than those for treatment, payment, or health care operations. Please make your request in

writing to us. We will respond to your request as soon as possible, but no later than 60 days from the date of your request. We will provide you with one accounting every 12 months free of charge. We will charge a reasonable fee based upon our costs for any subsequent accounting requests.

- **Right to a copy of our Notice of Privacy Practices and Policies.** We will ask you to sign a written acknowledgement of receipt of our Notice of Privacy Practices and Policies. We may periodically amend this Notice of Privacy Practices and Policies and you may obtain an updated Notice at any time.

8. Complaint Procedure

- **Within our Practice:** If you have a complaint about the denial of any of the specific rights listed in Section 7 above, about our Notice of Privacy Practices and Policies, or about our compliance with state and federal privacy law you may get more information about the complaint process by contacting NorthShore Health Center at 219-763-8112. We will respond to your complaint in writing within the time-frames listed in Section 7 above or in any case within 30 days of the date of your complaint.
- **Outside our Practice:** If you believe that NorthShore Health Center is not complying with its legal obligations to protect the privacy of your PHI, you may file a complaint with the Secretary of the U.S. Department of Health & Human Services, Office of Civil Rights.
- We will not retaliate against you for filing a complaint.

9. Marketing & Fundraising

- **Fundraising Use:** NorthShore Health Center may use patient information for the express purpose of the organization's own internal fundraising activities. The information used shall be limited to contact information and dates of services rendered.
- **Patients Right to "Opt Out":** NorthShore Health Center shall provide all patients with an opportunity to "opt out" of having such information used for development purposes. In order to do so, we ask patients to contact our Office, 219-763-8112
- **Marketing Use:** NorthShore Health Center shall obtain a patient authorization for use or disclosure of PHI for marketing purposes. If the marketing is expected to result in direct or indirect remuneration from a third party, the individual shall be notified that such remuneration is expected.

10. Psychotherapy Notes

- NorthShore Health Center shall obtain a patient authorization for use or disclosure of psychotherapy notes.

11. Breach Notification

- NorthShore Health Centers recognizes our patient's rights to notification after a breach of unsecured PHI as outlined and required by HIPAA. Affected individuals will be notified without reasonable delay, but in no case later than sixty (60) calendar days after discovery, unless instructed otherwise by law enforcement or other applicable state or local laws.

12. Effective Date. This Notice is effective as of **May 2016.**

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Dear Patients,

To better serve you, our staff has information for the following services. Please check any you are interested in or may need access to and return to the Receptionist so we can better assist you.

☐ Prenatal or Family Care Program

☐ GED/Adult and Alternative Education

☐ Housing

☐ Clothing

☐ Food Stamps

☐ Vision

☐ Rent or Mortgage Assistance

☐ Emergency Assistance

☐ Medical Home

☐ Affordable Care Act

☐ Domestic Violence Assistance

☐ Drug Abuse Rehabilitation

☐ Homeless Shelters -
If you checked "Homeless Shelters" Box, please specify: ☐ Lake County ☐ Porter County

☐ Dental

☐ Employment

☐ Food Pantries

☐ Utilities Assistance

☐ Legal Assistance

☐ Social Security

☐ Child Care

☐ Special Needs / Special Education

☐ Budget and Money Management

☐ Credit Repair

☐ WIC Program

☐ Infant/Child Items Assistance

Printed Name: _____

Signature: _____

Date of Birth: ____ / ____ / _____

Phone Number: _____

Date: ____ / ____ / _____

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Thank you for choosing NorthShore Health Centers. We are always looking for ways we can improve our quality of care and better serve our patients. Please complete the following information selecting the most appropriate answer.

1. How likely is it that you would recommend our service to a friend or colleague?
   0 1 2 3 4 5 6 7 8 9 10
   Not Likely **Very Likely**

2. The office environment, cleanliness and comfort including exam room, patient waiting area, bathrooms, etc. at NorthShore was:
   Excellent Very Good Good Fair Poor

3. Did front desk and receptionists at this provider's office treat you with courtesy and respect?
   Excellent Very Good Good Fair Poor

4. Wait time includes time spent in the waiting room and exam room. At your last appointment at NorthShore, what was your total wait time?
   Under 10 10-15 16-30 31-45 Over 45

5. Level of trust in my provider's plan of care:
   Excellent Very Good Good Fair Poor

6. How well did provider listen carefully to you and explain things in a way that was easy to understand?
   Excellent Very Good Good Fair Poor

7. Did this provider spend enough time with you?
   Excellent Very Good Good Fair Poor

8. When you phoned this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?
   Always Usually Sometimes Never N/A

9. When you phone this provider's office after regular office hours, how often did you get an answer to your medical questions as soon as you needed?
   Always Usually Sometimes Never N/A

10. When provider ordered a blood test, x-ray, or other test for you, how often did someone from NorthShore follow up to give you those results?
    Always Usually Sometimes Never N/A

11. Did anyone at NorthShore Health Centers talk with you about specific goals for your health?
    Always Usually Sometimes Never N/A

12. If you used the Patient Portal in the last 6 months, for which services did you use it? (Circle all that apply)
    Communication with Doctor
    Refill Meds
    View Health Records
    Request Referral
    Lab Results
    Pay Bill
    Schedule Appointment
    N/A – I do not have a portal account
    N/A – I have an account but do not use it

13. Number of office visits you've had in the last 2 years:
    0-1 2-5 6-10 11-30 31-60 61-100 100+

14. Your gender
    Female Male

15. Your age group:
    18-24 25-34 35-44 45-54 55-64 Over 64

Please add any additional comments:

Circle Location: Stacy Mckay Scottsdale Lake Station Lake Station-Dental Merrillville Hammond Chesterton

Updated 2/2018