



NORTSHORE HEALTH CENTER'S

Name: _____ **Date:** ____/____/____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: ____ - ____ - ____ **Emergency:** ____ - ____ - ____

Have you applied for Medicaid? Yes No When did you file last? _____
 Have you applied for Medicare? Yes No
 Do you have private insurance? Yes No
 Are you a veteran? Yes No

HOUSEHOLD INCOME

Members of family and all others living in the household (List each person separately)

Name	Relation to Applicant	Date of Birth	Race	Marital Status	Social Security Number	All other incomes AFDC, SS, Pension, Supp.	Monthly Gross Income

Is anyone in the household pregnant? Yes No

Cash assets available (checking, savings, etc.): _____

Total number in family & others in household: _____ Total gross monthly income: _____

I am currently receiving services from: _____ Doctor: _____

Other: _____

Office use only:	Approved-Income % Factor _____
	Denied-Reason _____

How did you hear about NorthShore Health Centers? _____

The information I have provided is true and correct to the best of my knowledge. I certify I will contact the facility in the event I have an insurance and/or income change. I certify under penalties of perjury that the information I have given on this application is true and correct to the best of my knowledge and belief.

Signature of Applicant

Interviewer

Office use only

Other extenuation circumstances or emergency situations with the individual or family:

Reason for medical visit:

Referrals made today (to be placed in patient file):

Registration Form

Patient Information

First Name _____

Parent or Guardian

Last Name _____

Name _____

Address _____

Phone # _____

Rent or Own Home _____

Date of Birth _____

City, State, Zip _____

Relationship to Patient _____

Township _____

E-mail _____

Emergency Contact

Phone # _____

Name _____

Soc Sec # _____

Address _____

Birth Date _____

City, State, Zip _____

Phone # _____

Relationship to Patient _____

Gender Male Female

Language English Spanish Other _____
Race African American Asian American Indian Caucasian Pacific Islander Native Hawaiian Other

Ethnicity Hispanic Non-Latino Refused to report

Military Status
 Active Active Reserve
 National Guard General discharge
 Retired Honorable discharge
 Separated Other discharge

WIC Are you currently enrolled in the WIC program? Yes No

Income Level \$0-\$5,000 \$5,000-\$10,000 \$10,000-\$15,000 \$15,000-\$20,000 \$20,000-\$30,000 >\$30,000

Homeless Yes No

Complete this section if you have insurance (Commercial, Medicaid, Medicare or Other)

Name of Company _____

Effective Date _____

Insured Person _____

Insured Person's Date of Birth _____

Insured Soc. Sec. # _____

Group number _____

Patient Relationship to Insured Patient _____

ID Number _____

Attach copy of insurance card (Front & Back)

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 claim or any other collection process. I request that any money due to me for medical benefits 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 costs if my account becomes delinquent.

Patient Signature _____ **Date** _____

Name _____ Today's date _____

Age _____ Birth date _____ Date of last physical examination _____

What is the reason for this visit? _____

Symptoms: Check symptoms you currently have or have had in the past year.

General

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headaches
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweat
- Loss of consciousness

Muscle/Joint/Bone Redness, Swelling, Pain, Weakness, Numbness in

- Arms
- Back
- Feet
- Hands
- Shoulders
- Hips
- Legs
- Neck

Genito-Urinary

- Blood in Urine
- Frequent Urination
- Lack of Bladder Control
- Night time urination
- Painful Urination

Gastrointestinal

- Appetite poor
- Bloating
- Bowl Changes
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion/Heartburn
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting/Vomiting blood

Cardiovascular

- Chest Pain
- High or Low Blood pressure
- Irregular Heart Beat
- Short Breath at night
- Swelling of Ankles, Hands, Feet
- Varicose Veins

Eye, Ear, Nose, Throat

- Bleeding Gums
- Blurred Vision
- Crossed Eyes
- Difficulty Swallowing
- Double Vision
- Earache
- Ear Discharge
- Hay Fever
- Infected Eyes
- Loss of Hearing
- Nosebleeds
- Persistent Cough
- Recurrent Sore Throat
- Ringing in Ears
- Sinus Problems
- Vision-Changes
- Vision-Flashes
- Vision Halos

Skin

- Bruise easily
- Hives
- Itching
- Changes in Moles
- Rash
- Scars
- Sore that won't heal

Men Only

- Breast Lump
- Erection Difficulty
- Lump in Testicles
- Penis discharge
- Sore on Penis
- Other

Women only

- Abnormal Pap Smear
- Bleeding between Periods
- Breast Lump
- Extreme Menstrual Pain
- Hot Flashes
- Nipple Discharge
- Painful Intercourse
- Vaginal Discharge/Itching
- Other

Symptoms: Check symptoms you have currently had in the past year.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hiv Positive | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Colitis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Scarlet Fever/Scarlitina |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Asthma/Hay fever | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Bladder disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Gonorrhea/Syphilis | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Gout | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Nervous Breakdown | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Vaginal infections |
| <input type="checkbox"/> Bursitis, Sciatica or Lumbago | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High Cholesterol | | |

Medication: List medication you are currently taking	Allergies/Reactions: To medications or substances

Family History

Relation	Age	State of Health	Age of Death	Cause of Death	Check if your blood relatives had any of the following	Relationship
Father					Asthma, Hay Fever	
Mother					Cancer	
Brothers					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
					High Blood Pressure	
Sisters					Kidney Disease	
					Seizure	
					Tuberculosis	
					Other	

Hospitalizations/Surgeries

Year	Hospital	Reason for Hospitalization and Outcome	Pregnancy/Menstrual History
			Age at onset _____ Regular cycle: Yes No Varies ____ days from start to finish Flow: Heavy Medium Light Date of last period _____ Date of last Pap _____ Neg. Pos. Do you take birth control pills? _____ Pregnancies: ____ Live Births ____ Still Births ____ Premature ____ C-section ____ Miscarriage ____ Abortion

Weight: Now _____ Have you had a blood transfusion? Yes or No
1 Year Ago _____ If yes, please give approximate dates:

Health Habits – Which substance you use and describe how much you use.

Serious Illness/Injuries	Date	Outcome	Caffeine	Tobacco	Drugs	Other

Immunizations	Date	Outcome
Tetanus		
Flu		
Pneumovac		

Occupational Concerns: Check if your work exposes you to the following.

	Stress	
	Hazardous	
	Heavy Lifting	
	Other	

Occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/hers staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____

CAGE AUDIT

AUDIT – C Questions

1. How often do you have a drink containing alcohol?
 0 = Never
 1 = Monthly or Less
 2 = 2-4 times a month
 3 = 2-3 times a week
 4 = 4 or more times a week

2. How many drinks containing alcohol do you have on a typical?
 0 = 1 or 2
 1 = 3 or 4
 2 = 5 or 6
 3 = 7 or 9
 4 = 10 or more

3. How often do you have 6 or more drinks on one occasion?
 0 = Never
 1 = Less than monthly
 2 = Monthly
 3 = Weekly
 4 = Daily or almost daily

CAGE Questions	Yes or No
Have you ever felt you ought to cut down your drinking or drug use?	
Have people annoyed you by criticizing you're drinking or drug use?	
Have you ever felt bad or guilty about your drinking or drug abuse?	
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	

STOP HERE

Scoring for clinician use only

This worksheet is a combination of the 4- item CAGE and 3 – item AUDIT – C. There is no “total” score, you interpret each section separately.

CAGE Questionnaire

Answering yes to 1 or more questions supports referral for more assessment.

AUDIT – C Questionnaire

A score of 3 or more for women and 4 or more for men supports referral for more assessment.

Total Score _____

Patient Health Questionnaire Modified

Name: _____ Clinician: _____ Date: _____

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	Not At All 0	Several Days 1	More than half the days 2	Nearly every day 3
1. Feeling down, depressed, irritable or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep or sleeping too much?				
4. Poor appetite, weight loss or overeating?				
5. Feeling tired or having little energy?				
6. Feeling bad about yourself or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite-being so fidgety or restless that you were moving around more than usual?				
9. Thoughts that you would be better off dead or of hurting yourself in some way?				
In the past year have you felt depressed or sad most days, even if you felt okay some times? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people? <input type="checkbox"/> Not difficult at all <input type="checkbox"/> Somewhat difficult <input type="checkbox"/> Very difficult <input type="checkbox"/> Extremely difficult				
Has there been a time in the past month when you have had serious thoughts about ending your life? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Have you ever, in your whole life tried to kill yourself or made a suicide attempt? <input type="checkbox"/> Yes <input type="checkbox"/> No				

** If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your health care clinician, go to the hospital emergency room or call 911.

Office use only: **Severity score:** _____

SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES

NorthShore Health Centers

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Please review the full Notice of Privacy Practices (NPP) which is attached. If you have any questions about this notice, Please contact, Privacy Officer at (219) 763-8112.

Who will follow this notice:

- NorthShore Health Centers

This notice describes our privacy practices. All these entitled, sites, and locations follow the terms of this notice. In addition, these entitled, sites, and locations may share health information with each other for treatment, payment, or health care operations purpose described in this notice.

Our pledge regarding health information:

We understand the health information about you and your health care is personal. We are committed to protection health information about you. We create a record of the care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to health information about you and follow the terms of the notice that is currently in effect.

How we may use and disclose health information about you.

The following categories described different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization.

There are also various other ways in which we may use or disclose your information:

- Appointment reminders
- To allow oversight of quality of the healthcare we provide
- To allow workers compensation claims

- AS required by subpoena in lawsuits and disputes
- Various uses as required by law or to avert a serious threat to health or safety

The full details for all these uses are contained in the full NPP.

Your rights regarding Health information about you

You have the following rights regarding health information we maintain about you:

- Right to inspect and copy
- Right to amend
- Right to an accounting of disclosure
- Right to request restrictions
- Right to request confidential communications
- Right to a paper copy of this notice

Information on how to exercise these rights can be seen in the NPP or can be obtained from, Privacy officer at (219) 763-8112.

Changes to this notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Privacy Officer. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

Other Uses of Health Information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

- About a death we may be the result of criminal conduct;
- About criminal conduct at our facility; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Coroners, health examiners and Funeral directors: We may release information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective services for the President and others: We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institutional.

Your rights regarding health information about you

You have the following rights regarding health information we maintain about you:

Rights to inspect and copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records.

To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to a privacy officer. If you request a copy of the information, we may charge a fee for the costs for copying, mailing or other supplies and services associated with your records.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing, Submitted to a Privacy officer, and must be contained on one page of paper legibly handwritten or typed in at least 10 point font size. In addition, you must provide a reason that supports your request for an amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for our practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you. If you do, we agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you may make your request in writing to a Privacy officer. In your request, you must tell us what information you want to limit and to whom you want the limits to apply; for example, use of any information by a specified nurse, or disclosure of specified surgery to your spouse.

Right to a paper copy of this notice: You have the right to obtain a paper copy this notice at any time. However, at the time of first service rendered after April 14, 2003, it is required that you receive a paper copy. To obtain a copy, please request it from a Privacy officer.

Changes to this notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Privacy Officer. All complaints must be submitted in writing.

Other uses of Health information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission in writing at anytime. If you revoke your permission we will no longer use or disclose health information about you for reason covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain for our records of the care that we provided to you.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received the Notice of Privacy Practices from
NorthShore Health Centers.

X _____ Date: ____/____/____

In lieu of patient signature, I, _____, a staff member of NorthShore
Health Centers, state that _____ has been given our current
Notice of Privacy Practices.

X _____ Date: ____/____/____



Disclosure of Protected Health Information

THIS FORM IS TO PROTECT YOUR CONSENT TO USE
OR DISCLOSE YOUR PROTECTED 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: _____

Your Address: _____

Your Telephone Number: _____

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

Name the people and/or organization that you are consenting to receive and use your protected health information.

2. ENDING THIS CONSENT

This consent will end on the following date: _____

3. CHANGING YOUR MIND ABOUT THE 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 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 SIGNATURE

I have had the chance to read the content of this 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 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: _____

Patient Responsibilities

It is our goal at NorthShore Health Centers to provide you with quality primary health care. We are entering into a partnership with you for your health and well-being. In order to provide you with the best care possible, your cooperation is expected and appreciated.

Appointments- Our hours are by appointment. If you are not able to keep your appointment, call and cancel. That time is reserved just for you. If you don't show up, valuable time is wasted!

Medical History- The more complete you are giving us your health history, the better able we are to serve you. This includes all medications that you take, including over the counter drugs.

Language- If you have any difficulty speaking or understanding English, if possible, bring an interpreter with you.

Questions- If there is any aspect of your care that you don't understand or aren't sure of, you need to ask us!

Courtesy- You should expect to be treated with respect and courtesy. We will respect your time and your intentions; we expect the same from you.

Education- You are the best advocate when it comes to your health. We strongly urge you to take advantage of health education classes as they are offered.

Personal Information- Keep us informed of any change in address or phone number.

Updates- Every six months, you will need to provide us with a written record of your current income. (Pay stubs, tax statements, letter for employer)

Surveys- As a part of our quality improvement, we will periodically ask you to fill out a survey.

Off Site Healthcare- If you seek medical care outside of NorthShore Health Centers; you are responsible for any fees charges.

Medical Advice- You need to follow advice given by your Healthcare Provider. This includes taking medication only as prescribed and returning for follow up appointments. If you are having trouble getting your medication because the cost is too high, you need to tell your Healthcare Provider.

***REMEMBER, you are now part of NorthShore Health Centers. The success of this clinic depends our working together as a team. Help us to make this effort a success.**

This list of patient responsibilities has been explained to me and I have received a copy. I understand that as a partner in my health care at NorthShore Health Centers, I am expected to follow the guidelines above.

Patient Signature

Date

Witness



A Federally Qualified Health Center

3564 Scottsdale St., 6450 US Hwy. 6, Portage, IN 46368 * 3099 Central Ave.,
2490 Central Ave., Lake Station, IN 46405 PH: 219.763.8112

PAYMENT POLICY

Your health is important to us and we want to continue to be here when you need us!

NorthShore Is Not A “Free Clinic”, but is a Not-For-Profit Community Health Center which provides quality healthcare to all, regardless of ability to pay. Everyone must pay their sliding fee, which is determined by their income. (All are charged the base amount).

- ◆ Your situation has been reviewed, and a reasonable fee has been determined. It is expected that you will pay that reasonable amount at time of service.
- ◆ If you have insurance: Medicare, Medicaid, or Private Insurance, notify intake personnel at the time of your interview.
- ◆ If your insurance situation should change in the future, notify us at the time you make an appointment.
- ◆ If you do not show for your appointment and you do not call within 24 hours to cancel or reschedule, there will be a \$25.00 charge.
- ◆ If you have two no-shows, you will no longer be able to schedule an appointment. You may walk in and wait until an opening becomes available.
- ◆ If you are sliding fee/self pay patient: You will be responsible for any additional charges that may be incurred, in addition to your office visit (labs, x-rays, EKG, etc).
- ◆ Payment due is expected when service is rendered. Any exceptions must be approved by billing coordinator.
- ◆ 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 monthly service fee of \$5 and a minimum of \$125.00 in legal fees including court cost, and attorney fees.
- ◆ With each patient taking responsibility for their portion, we will be able to continue to provide you with quality health care.
- ◆ By working together, we will ensure that NorthShore Health Centers are available to all who need our services.

I have read the payment policy and understand that the fee assigned to me is payable at the time of service.

Printed Name

Signature

Date