NORTHSHORE 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 ____

OVER ⇒⇒⇒⇒

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):

NorthShore Health Centers

Patient ID Number _______________

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 ______________________________
Insured Person ________________________________
Insured Soc. Sec. # _____________________________
Patient Relationship to Insured Patient ______________
Attach copy of insurance card (Front & Back)

Effective Date __________________________
Insured Person's Date of Birth ___________________
Group number _______________________________
ID Number ___________________________________

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** ____________________

This page is to be completed by registration staff

Insurance Confirmation (insured patients only)

Insurance Card copied and attached? ___ Yes ___ No

Income/Social Verification (sliding scale patients only)

Check stub copied and attached? ___Yes ___No Annual Earnings ______________

Employer(s)/income source # of Family Members _____________

Pay Frequency ___Daily ___Weekly ___Every 2 Weeks ___Monthly ___Other______________

If check stub is not copied and attached, please check the applicable reason below:

___ First time visit/unaware of requirements (1 day limit)

___ Non-complaint spouse regarding income proof (1 year limit)

___ Unaccompanied minor, no proof available (1 year limit)

___ No income, need letter of support

___ Proof is filed under another patient's account number (Expiration the same as patient with proof filed)

Proof filed under account number: _____________________________

If none of the above choices are applicable and no proof of income is available for an uninsured patient, an explanation for determining eligibility may be provided and initialed below by the supervisor at the time of application:

___ Sliding scale per supervisor approval – See notes below for explanation (1 year limit)

____

____

____

Supervisor Initials ___________

Financial Class Determination (all patients)

Fee for service insurance ___ Medicaid ___ Medicare ___ Commercial

Hoosier Health assigned to NSHC ___ Anthem Hoosier ___ MHS Hoosier ___ MD Wise Hoosier

Sliding Scale ___ $20 visit

Self Pay ___ 100%

Effective Dates _____________ to ______________

Registration initials and date ____

NorthShore Health Centers

Health History
Confidential

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.

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

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

	Substance	
	Caffeine	
	Tobacco	
	Drugs	
	Other	

Immunizations	Date	
Tetanus		
Flu		
Pneumovac		

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

	Exposure	
	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: ______________________________

NorthShore Health Centers

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 tires 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?
- ☐ Yes
- ☐ 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?
- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life?
- ☐ Yes
- ☐ No

Have you ever, in your whole life tried to kill yourself or made a suicide attempt?
- ☐ Yes
- ☐ No

** If you have had thoughts that you would be better off dead or of hurting yourself in someway, pleases 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: ____

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 and 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**

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 wall-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 you r 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

3564 Scottsdale St., 6450 U.S. Highway 6, Portage, Indiana 46368 2490 Central Ave.,
3009 Central Ave. Lake Station, Indiana 46405
Ph 219.763.8112
www.northshorehealth.org

Dear Patients,

To better serve you, our Social Services Coordinator has information for the following services, please check any you are interested in and return to the Receptionist so she can schedule an appointment for you:

- ☐ **Consumer Credit Counseling of NW Indiana**
- ☐ **Division of Family & Children (Food Stamps/Medicaid).**
- ☐ **Family & Youth Services Bureau**
- ☐ **Indiana Legal Service, Inc.**
- ☐ **KV Works (Help with Employment)**
- ☐ **Family Planning NSHC**
- ☐ **Dental NorthShore Health Center**
- ☐ **Portage Adult Ed**
- ☐ **Porter County Family Counseling Center (No Children)**
- ☐ **Behavioral Health NorthShore Health Centers**
- ☐ **Pharmacy NorthShore Health Centers**
- ☐ **Salvation Army**
- ☐ **Social Security**
- ☐ **Spring Valley (Homeless Shelter)**
- ☐ **The Caring Place (Abused Women)**
- ☐ **Township Trustee (Help with rent, utilities…..)**
- ☐ **Vocational Rehabilitation Services**
- ☐ **WIC**

NAME: ______________________________________ **PHONE #:** _____________________ **Date:** __________