**KNOX COMMUNITY HEALTH CENTER**
**ACKNOWLEDGEMENT OF OFFICE POLICIES**

Thank you for choosing the Knox Community Health Center (KCHC) for your medical and dental health care needs. Our staff values your time and hopes you will, in return, value ours. In order to serve you better we have the following office policies for you to review and sign. Agreeing to these policies will enable us to provide better care to you in a timely and efficient manner.

1. All patients are required to complete *eligibility* during their registration visit. Fees for the KCHC are based on the patient's household size and income. It is the patient's responsibility to provide current information for this purpose.

2. Services rendered are expected to be paid for at the time of service; the KCHC accepts cash or check only. Any other payment arrangements should be made in advance of services.

3. Patients must provide the KCHC with a valid contact phone number and current address and update this information with staff as necessary.

4. If you are unable to keep a scheduled appointment 24-hour advance notice of cancellation must be provided. Patients arriving more than ten (10) minutes late for their appointment will be asked to reschedule.

5. Patients who are identified as chronic "no shows" will be notified that they are only allowed to schedule the next last available appointment until such time when two consecutive appointments have been kept. During that period, emergency treatment will be provided on a call-in basis only and will have to be approved by the provider.

6. Patients experiencing a need for urgent medical or dental care may call the KCHC at the beginning of the day and will receive a return call by the end of that day; same day emergency appointments are not guaranteed.

7. For patients with insurance coverage, including Illinois Medicaid, eligibility for services will be determined before the start of each visit. You must bring your insurance card and photo identification to each appointment. If eligibility cannot be verified, you may be asked to pay for services or reschedule. Any services not covered by insurance will be your responsibility to pay.

8. In most circumstances, minors perform significantly better in the dental chair when parents remain in the waiting room. Therefore, parents will be asked to remain seated in the waiting room. Dental staff will keep you updated on your child's progress during the appointment.

9. Parents and/or guardians bringing a child to a medical or dental appointment will be expected to stay on the premises, during the child's appointment. We regret that we are unable to schedule more than two members from one household on the same day.

10. Although every attempt is made to ensure a very positive experience at the Knox Community Health Center, perfect results cannot be guaranteed. We strive to avoid adverse outcomes, but these cannot be eliminated entirely. Those may include pain, dry socket, allergic reactions, esthetic compromises etc. After treatment patient education and instruction sheets are given to patients that have fillings, extractions etc. ; however, if the pain or reaction goes beyond normal, please call for further instructions, or go to the Emergency Department.

*The Knox County Community Health Center reserves the right to refuse service to verbally or physically abusive patients and/or their parents. These behaviors will be documented and will result in dismissal from the Health Center.*

***I have read and understand the above written policies and hereby agree to abide by them during my care at the Knox Community Health Center. I further understand that if I do not provide the necessary information, I will be expected to pay 100% for all services rendered.***

Signature _____ Date _____

**ACKNOWLEDGEMENT OF PROVISION**
**OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that, on the undersigned date, I was provided the Notice of Privacy Practices for the Knox County Health Department.

I understand that protected health information will only be disclosed as outlined in the Notice. I may contact the Privacy Officer at the Knox County Health Department if I have any questions.

I may file a complaint with the Health Department as stated in the Notice, and/or request the address of the U.S. Department of Health and Human Services Office of Civil Rights to submit a written complaint, if I feel my privacy rights have been violated. I understand the Knox County Health Department will not retaliate in any way if a complaint is filed.

Patient Name: _____
(Please Print)

Date of Birth: _____

Patient/Guardian Signature: _____ Date_____

Relationship to Patient: _____

**FOR STAFF USE ONLY**

I attempted to obtain an Acknowledgment of the Receipt of the Notice of Privacy Practices on behalf of the Knox County Health Department and was unable to obtain the Acknowledgment because:

___ Client refuses to sign

___ Other_____

Staff member's initials _____

Date_____

# Knox Community Health Center
# Consent for Dental Treatment

**Patient's Name** _____ _____ _____ _____
**First** **MI** **Last** **Date of Birth**

I hereby authorize the Community Health Clinic dentist and staff to perform dental treatment on the above named patient.

I request and authorize them to do whatever they deem advisable if any unforeseen condition arises in the course of treatment, calling, in their judgment, for procedures in addition to or different from those now contemplated.

**I consent to treatment after having been advised of the risk, advantages, and disadvantages of the treatments and the consequences if this treatment is withheld.**

I consent to the treatment plan after having been advised of the alternative plans of treatment available and the known material risks, advantages, and disadvantages of the alternative treatment.

I further consent to the administration of local anesthesia, antibiotics, analgesics or any other drugs that may be necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (e.g., allergic reactions), cardiac arrest, aspiration, and thrombophlebitis (.e.g., irritation and swelling of the vein) pain, discoloration and injury to blood vessels and nerves, which may be created by injections of any medications or drug.

I am informed and fully understand that inherent in any type of procedure are certain unavoidable complications. In oral procedures, the most common of these complications include post-procedure bleeding, swelling or bruising, discomfort, stiff jaws, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g., numbness in mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations and small root fragments remaining in the jaw which might require extensive surgery for removal.

I realize that in spite of the possible complications and risk, the contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the procedure.

I have provided as accurate and complete medical and personal history as possible including those antibiotics, drugs, medications, and food to which I am allergic. I will follow instructions as explained and directed to me and permit prescribed diagnostic procedures.

**Parent/Guardian Signature** _____ **Date** _____

**Patient Signature** _____ **Date** _____

# Knox Community Health Center
# Consent for Medical Treatment

**Patient's Name** _____ _____ _____ _____
**First** **MI** **Last** **Date of Birth**

I hereby authorize the Knox Community Health Clinic to perform medical treatment on the above named patient. I consent to the provision of medical and/or surgical care by Knox Community Health Center and physicians and health care personnel providing Services at the Knox Community Health Center. Such care may include, but is not limited to, diagnostic and therapeutic tests and procedures and treatment as may be ordered by any provider, and/or his/her designees. I specifically consent to the testing of my blood for infectious diseases of any nature and description including, but not limited to, hepatitis, syphilis, gonorrhea or human immunodeficiency virus (HIV) (causative agent of AIDS), if determined by my attending physician to be necessary: (1) to determine the appropriate treatment for me; or (2) for the protection of the attending physicians and health care personnel caring for me who are exposed to my blood or body fluids.

I understand that the practice of medicine is not an exact science. I acknowledge that no guarantees have been made to me as to the diagnosis or treatment. I have the right to consent or to refuse consent to any proposed test, medical procedure or therapeutic course of treatment. Any authorization or consent that I give may be canceled or revoked by me in writing at any time. I am aware that physicians, nurses, and other health care personnel who are in training may provide care to me, unless I direct otherwise in writing, such personnel may be present and assist with my care as part of their education.

I agree that I am individually obligated to pay the full charge of all services rendered to me at the Knox Community Health Center if my Payor does not provide benefits for services I receive at the Knox Community Health Center.

I agree that I (or another person who specifically agrees to guarantee payment for me) am responsible for any applicable coinsurance payments and deductibles and all amounts for which my Payor has denied payment with these amounts being due within 10 days of the billing date. Amounts due from me to Knox Community Health Center prior to the execution of this agreement may, at the sole discretion of Knox Community Health Center and may be consolidated with, and made a part of, the amount due hereunder.

I irrevocably authorize direct payment to the Knox Community Health Center of any Payor benefits otherwise payable to or on my behalf for services rendered. I understand that I am financially responsible for charges not covered by my Payor. I authorize Knox Community Health Center to act as attorney-in-fact for the collection of Payor benefits or from any responsible third party through whatever legal means necessary and the endorsement of benefit checks made payable to the patient or me**.**

I have provided as accurate and complete medical and personal history as possible including those antibiotics, drugs, medications, and food to which I am allergic. I will follow instructions as explained and directed to me and permit prescribed diagnostic procedures.

**Parent/Guardian Signature** _____ **Date** _____

**Patient Signature** _____ **Date** _____

# Authorization for Release of Protected Health Information

I, _____ hereby authorize the Knox County Health Department
(Name of Patient or Personal Representative)

**To release the information listed below to:**

_____
(Name of Person/Entity to Receive Information)

_____
(Street Address) (City) (State) (Zip)

From the designated record set of _____whose birth date is _____
(Patient's Name)
And whose address is_____

**The following information shall be released (mark all applicable):**

☐ Entire Medical Record, Except for Records Concerning Mental Health Treatment Alcohol, or Other Drug Treatment, HIV/AIDS Information, and Genetic Information.

**Or, only records specific to:**

- ☐ Mental Health Treatment Records
- ☐ Alcohol or Other Drug Treatment Records
- ☐ HIV/AIDS Records
- ☐ Genetic Information
- ☐ Other:

_____

_____

- ☐ Immunization Records/ Well Child Visits
- ☐ X-Ray or Other Photographic Reports
- ☐ Laboratory Reports
- ☐ Dental

The purpose of the authorization is:

- ☐ At the Request of the Individual or Personal Representative
- ☐ Other:_____

The information should be released for the following time period: from _____ to _____.
(Start Date) (End Date)

I understand that I have the right to revoke this authorization by giving written notice to the health department. I understand that if the health department has already used or released my health information in reliance on this authorization, that I cannot revoke the authorization. If I refuse to sign this authorization, the above-described health information will not be disclosed except as provide by law.

I understand that the health department may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization unless I am to receive health care solely for the purpose of creating protected health information to be disclosed to a third party or as otherwise authorized by law.

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that this authorization is valid until the date of expiration listed below, or until I revoke it in writing by delivering a written revocation to the health department.

I have a right to inspect and copy the information contained in my designated record set. I am entitled to a copy of this authorization if the health department is seeking this authorization.

This authorization for release of protected health information terminates on _____.
(Date)

Signature: _____ Date: _____.

If you are the personal representative of the patient, please specify your relationship to the patient: _____.