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Health Center of Illinois

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CLIENT INFORMATION

Last Name: _____ First Name: _____

Date of Birth: ____/____/_____ Social Security # _____-_____-_____

Address (including apartment, city and zip code): _____

_____

May we send mail to the address you have listed? No____ Yes____
May we telephone you? no ____yes____ phone# _____
May we leave a text message at this phone number? No____ Yes_____ Text #: _____
May we send email messages? No____ Yes____ email _____
May we leave a voicemail message on the phone # above? Yes No Detailed or Brief?
Please Note: Email from Open Door Clinic is not encrypted.
How did you hear about us? Insurance Company_____ Family/Friend _____Web-site_____
Outreach_____Other_____

Name(s) of any Physicians you receive care from other than Open Door Health Center:

_____

_____

Pharmacy you use _____ Pharmacy Phone Number _____

Case Manager _____ Behavioral Health Provider _____

I select: Dr. Fidai, MD: _____ Sofia Figueroa, NP : _____ Josh Lopez, NP : _____ as my primary clinician. I understand that I may change this at a later date upon my request.

For our funding, we must have copies of your I.D., insurance, and income amount. You will be asked to update this information semi-annually.
PLEASE CHECK ALL THAT APPLY:

___ Medicaid Attach copy, both sides

___ Medicare Attach copy

___ Private Insurance Attach copy, both sides

___ Veteran's Health Benefits Attach copy

___ I have no Private Insurance, Medicaid, Medicare Insurance or Veteran's Health Benefits. I am requesting to apply for Open Door Clinic Sliding Fee Discount.

I receive the following amount of income each month _____ from _____
(Please include all sources of income.) We need verification of income (Check stubs or tax returns)
The number of persons in you household for which you are legally responsible is _____.
I, hereby certify the above information to be correct.

_____ _____
Signature **Date**

Preferred Name or Nickname: _____

Sex at birth: ____Female _____Male

What is your current gender Identity?

Sex: _____ Female _____ Male _____Transgender ID as Female _____Transgender ID as Male

What sex is listed on your health insurance or government records? _____ Female _____ Male

What is your sexual orienation? ___ Homosexual _____ Heterosexual _____Bisexual _____Lesbian _____ Other

_____

What best describes your race?

___African American/Black ___Asian ___Pacific Islander
___Caucasian/White ___Hispanic/Latino ___Multiracial
___Native American/Alaskan Native/Inuit ___Other:_____

What is your country of birth? _____
What is your primary language?
___English ___Spanish ___Burmese ___French ___Russian ___Polish
___Other: _____

Do you need an interpreter with you during your appointments with our clinicians? Yes / No
Do you need any other special services or assistance during your appointment with us? Yes / No

If yes, please describe any other assistance you may need during your appointments with us:

_____

Do you have any other learning disabilities or problems understanding things that you may need additional assistance with? Yes / No

Are you a United States Veteran? Yes / No
Are you a Seasonal Worker? Yes/ No
Are you a Migrant Worker? Yes/ No
Are you Homeless? Yes/ No
Do you have limited English Proficiency? Yes/ No

Are you hearing impaired? Yes/ No
Are you Vision Impaired? Yes/ No

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Client Member Consent to Service Agreement

I,_____agree to actively participate in Open Door Health Center of Illinois' services outlined in the Service Plan that the staff and I have developed. This Service Plan will help to access needed resources and support.

I understand that Open Door Health Center of Illinois exists for the purpose of assisting people impacted by HIV, in receiving the level of advocacy, support, and assistance necessary to manage HIV.

I understand that program services include, but are not limited to primary care; case management; assessments, advocacy, information and referrals; linkages to external agencies; individual, couple and family counseling; support groups; dental; and educational services.

I understand that information regarding my request for services, the service I receive, or the extent of my discussions with Open Door Health Center of Illinois' staff will not be disclosed without my informed consent.

I agree to respect the confidentiality of other client member's in the agency, and will not disclose personal information discussed in-group sessions outside the agency.

I understand that Open Door Health Center of Illinois staff, need to periodically contact client members by phone, or conduct home visits, but in these instances will not disclose the nature of their contact to unauthorized persons.

I have received a copy of "Your Rights and Responsibilities" form and the agency "Grievance Procedure."

Confidentiality of client information is of the utmost importance in the provision of services, and Open Door Health Center of Illinois strives to protect the privacy and confidentiality of our clients. This policy is intended to ensure confidentiality of all clients' information and to define the parameters of appropriate disclosure.

Client Information is any information that can be used to identify a client with reasonable accuracy, either directly or by other publicly available information. Client identifying information includes the following: their name (first or last); social security number; address; date of birth; physical description; or photograph.

Disclosure is revealing information the identity, HIV status, or medical condition of any client receiving services. Any release of information, formally or informally, which would identify an individual as a client, either directly or by reference to other publicly available information, is disclosure. As a publicly identified service provider for persons with HIV/AIDS, indicating to a third party that someone is a client of the agency without the client's consent is disclosure and a breach of his/her confidentiality.

Consent for release of information, is client authorization, for disclosure of specific information to a particular recipient, for an explicit purpose. Before information about a client can be released or obtained by Open Door Health Center of Illinois the client must first be informed of the reason. Next, the client must sign a release of information to authorize staff to either release or obtain information pertaining to the client. A client may refuse to sign a release of information at any time for any reason.

Under the following circumstances, Open Door Health Center of Illinois staff may release information about a client without the client's prior consent and approval:

- when releasing information to a judge or court of law, when the client's records are subpoenaed by the court;
- when releasing medical information pertinent to a medical emergency (where blood is present) when the client or client's guardian or caretaker is unable to provide consent;
- when any other laws or regulations require disclosure, such as state reporting of HIV surveillance, without a client's consent.

Psychotherapeutic, psychiatric and other mental health services are confidential. We will not reveal any information you disclose in treatment to persons or agencies outside Open Door Health Center of Illinois without your written consent, except when required by law.

The law requires that we inform others outside the health center when one of the following conditions exists:

- When there is reason to suspect that child or elder abuse has occurred, regardless of when the abuse may have occurred.

- When there is reason to believe that a patient is likely to harm themselves, unless the service provider has taken protective measures.

- When there is reason to believe that a patient is likely to harm someone else.

Senior-level practitioners may supervise others in training at Open Door Health Center of Illinois. All supervisors adhere to the same professional guidelines as stated above. However, Open Door Health Center of Illinois cannot release any information regarding a client's HIV status under any circumstances without a signed release of information.

I have read and understand the information outlined, and I consent to treatment under these conditions. Give

permission for Open Door Health Center of Illinois staff to contact me via:

☐ US Postal Service: (Address)

_____

☐ Telephone Number:

_____

☐ E-mail:

_____

☐ Text:

_____

Any special provisions for ongoing contact with Open Door staff include the following:

_____

_____ _____

Client Member Signature Date

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Relationship (if signed by person other than client)

Staff Member Signature

Date

1665 Larkin Avenue | Elgin, Illinois 60123 | t • 847.695.1093 | f • 847.695.0501
157 S. Lincoln Avenue, Suite K | Aurora, Illinois 60505 | t • 630.264.1819 | f • 630.800.1062

United Way

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Statement of Client Rights and Responsibilities

I. Description of Services

A. Primary Care: Early intervention medical care consisting of physician services, nutritional screening, nursing, laboratory testing (limited), Psychosocial, Mental Health, Psychosocial & Substance Abuse (assessment, treatment plan, and recommendations), Dental Services (preventative, diagnostic, and therapeutic) and referrals for other specialty care services.

B. Case Management: Provide needs assessment, develop individualized service plans, and support and entitlement programs, resource referrals, and other services, which become part of the Case Management program.

II. Eligibility

A. Case Management/Mental Health-Substance Abuse Treatment/Psychosocial Services/Dental Care: Persons living with HIV disease in Kane, Kendall, Suburban Cook, Lake, McHenry, and surrounding counties.

B. Primary Care: Persons diagnosed with HIV disease unable to secure medical care from private physicians. Person must be over sixteen years old.

C. Open Door Health Center of Illinois reserves the right to limit or withhold any services based upon need and the compliance of each client.

III. Non-Discrimination Statement

Persons will not be denied service based on race, religion, sex, sexual orientation, handicap condition, nationality, legality, veteran status, social and/or economic status/group membership, literacy, homelessness and substance abuse, developmental disability, or mental health issue.

IV. Confidentiality

Open Door Health Center of Illinois respects your rights as an individual, and considers the protection of these rights as important to the agency. These rights include:

A. The right to seek help through our services without danger of disclosure. We will not give out any information about you or release any information from your file without your permission.

B. The right to have a private space for conversation, intakes, conferences, etc.

C. Clients are responsible for respecting the privacy and confidentiality of other clients receiving services at Open Door Health Center of Illinois, including not discussing client members with people outside the health centers.

D. Open Door Health Center of Illinois does have the responsibility to transmit electronically either by email or fax, confidential information for continuity of care, treatment, healthcare operations, and billing purposes. It is understood that all caution possible will be made to avoid email or fax information from being received in error by a third party. The use of email and fax will be limited to:

1. Communication with Open Door Health Center of Illinois physicians for continued medical care between medical health centers;
2. Billing purposes to 3rd party insurances, including Private insurance, Medicare, Medicaid, and Ryan White funding sources;
3. Communication with other medical resources for continuity where releases of information have been signed.

V. Clients Rights Are:

A. To have information kept in the strictest confidence in compliance with the laws of the State of Illinois.
B. To decline services at any time and sever the relationship between Open Door Health Center of Illinois and yourself.
C. To know where to register complaints and concerns.
D. To know what information about you is being released, to whom, and for what purpose.
E. To receive alternative services from other organizations with or without the assistance of staff.
F. To participate with Medical, Behavioral Health, and Case Management in formulating and executing a service plan.
G. To be treated with respect, civility, and courtesy by the staff of Open Door Health Center of Illinois.
H. Services will be provided in a safe and secure location.

VI. Clients Responsibilities Are:

A. To interact with the staff of Open Door Health Center of Illinois in a civil manner, openly and honestly.
B. To limit expectations of the programs to deliverable services as originally outlined.
C. To comply with the service plan created and agreed upon.
D. To participate fully and accept responsibility for tasks and actions.
E. To assume financial responsibility for services outside those of Open Door Health Center of Illinois, when those services are requested or suggested.
F. To inform Open Door Health Center of Illinois' staff of any changes that might affect services.
G. Illicit drugs, alcohol, implicit or explicit weapons are prohibited on agency's premises.
H. To not verbally or physically threaten staff.

VII. Grievance Procedure

Persons receiving services from Open Door Health Center of Illinois through Primary Care, Behavioral Health, or Support Services (DRS or Part A Case Management) have the right to file grievances with the agency pertaining to those services. The following procedure will be followed in order to address such grievances.

A. Discuss issue with person providing the particular service. An attempt of resolution might be obtained through discussion and mutual agreement between staff and Client.
B. If necessary, the Client will submit their grievance in writing to the Executive Director of Open Door Health Center of Illinois with specific details. The Executive Director will investigate and respond in writing within fifteen days of the receipt of the grievance.
Letters will be addressed to

Executive Director
Open Door Health Center of Illinois
1665 Larkin Avenue
Elgin, IL 60123

C. If necessary, a meeting will be arranged between the Executive Director, the pertinent staff members, the Client, and if desired, their representative. If resolution is not possible, efforts will be made by the staff of Open Door Health Center of Illinois to secure services for the Client through another provider.

D. At any point in the grievance process you may contact the Center for Conflict Resolution (CCR) to provide to you a confidential process to discuss your concern(s) with the agency in the presence of a neutral mediator to creation options and find a mutually agreeable solution. You may contact CCR through the following toll free number 1-866-CARE-212. For Part A Case Management or Part B services grievance please contact Mike Grego at 1-312-784-9089.

I have read my rights, responsibilities, and service descriptions as listed above. They have been explained to me and I fully understand them. I certify I have received a copy of these rights and responsibilities for future reference. I give my consent for emails and faxes to be sent as outlined in section IV on Confidentiality. I absolve Open Door Health Center of Illinois of all liability in the event an email or fax is received in error by a third party.

Please initial the correct response:
I do want a copy of the Rights and Responsibilities for my records. ____

I do not want a copy of the Rights and Responsibilities for my records. ____

Client Signature: _____ **Date:** _____

Relationship (if signed by person other than client): _____

Staff Signature: _____ **Date:** _____

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Provider Notice of Information

Uses and Disclosures of Health Information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Individual Rights

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you $.15 (15 cents) for each page. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your information for treatment, payment, and administrative purposes, except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request, but are not legally required to accept it.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. If you have any questions or complaints, please contact:

Open Door Health Center of Illinois
1665 Larkin Avenue
Elgin, IL 60123
Ph: (847) 695-1093

I have received a copy of this document:

Client Signature: _____ **Date:** _____

Relationship(if signed by person other than client): _____

Staff Signature: _____ **Date:** _____

OUT OF POCKET MEDICAL EXPENSE TRACKING FORM

Please put all receipts from medical expenses, including over-the-counter medications, into this envelope and bring to Open Door Health Center of Illinois with your appointments. Give to receptionist to review and return to you. Please provide a receipt to receptionist.

Name: _____

Spending Cap: _____

Examples: Medical Expenses	**Date**	**Amount**	**Running Total**
Vitamins	1/15/21	$9.99	$9.99
Mammogram	2/1/21	$40.00	$49.99
ODC Office Visit	2/15/21	$10.00	$59

Medical Expense	Date	Amount	Running Total

I acknowledge that the Caps Program was explained to me and I was given the medical expense tracking form.

Client Signature: _____ **Date:** _____

Relationship(if signed by person other than client): _____

Staff Signature: _____ **Date:** _____

SIGNATURE PAGE

With my signature, I authorize the Program and the entities identified in item 14 of this document to share my information with the additional entities listed below, and I understand that I must list these contacts on each submission of this form in order to allow the Program to continue to share my information with them.

_____
Individual Name (print)

(_____) _____ - _____ Is this individual aware of your status? ☐ Yes ☐ No
Telephone

_____
Individual Name (print)

(_____) _____ - _____ Is this individual aware of your status? ☐ Yes ☐ No
Telephone

_____
Individual Name (print)

(_____) _____ - _____ Is this individual aware of your status? ☐ Yes ☐ No
Telephone

Client First Name	**Middle Initial**	**Client Last Name**

Social Security Number (Leave blank if no valid SS number for client)	**Date of Birth (mm/dd/yyyy)**

I hereby acknowledge that I have received a copy of this document and recognize that I will be required to sign this document at each eligibility determination.

_____ / /
Client Signature (age 12 and older) **Date (mm/dd/yyyy)**

_____ / /
Parent/Guardian (if under 12) or Legal Representative **Date (mm/dd/yyyy)**