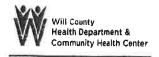


WILL COUNTY COMMUNITY HEALTH CENTER DECLARATION OF INCOME

PLEASE PRINT:				
Last Name:	Firs	it:	M.I	
Address:		City:	State:	Zip Code:
Email:			Gender: Male 🗆 Female 🗅	
Date of Birth:				
MM	DD YYYY			5
Housing: Rent Own	n Doubling Up Hom	eless Shelter Stre	et Transition	nal Unknown Other
	hite Asian Black/ nerican Indian/Alaska			
Ethnicity: (circle) Hi	spanic Non-Hisp	anic Vete	eran: (circle)	Yes No
Language Barrier: (ci	rcle) Yes No	Preferred Langua	ge:	
Family Size: (Include	yourself, spouse, and	d denendent child	en under the	age of 19)
*Income: Yes □ No	□ Income Amount: \$	wependent cilidi Waakki r	Ri-Wookly r	Monthly D Yearly D
*Proof of Income or	no income is required	by staff to undate	every 12 mor	the
		by stajj to apaate	every 12 mor	iuis.
Please check all sour	ces of income:			
□ I am employed/m	y spouse is employed	□ Unemployed	No Proof of I	ncome Provided
□ Unemployment Be		□ Food Stamps		
□ Social Security		□ Alimony		
☐ Social Security Dis	ability	□ Child Support	:	
☐ Supplemental Soci	al Security Income	□ Pension		
Employer's Name:	-			
Employer's Address:				
	City:	Ctata	71	
	City	State: _	Zip: _	•
I hereby attest that the	information provided a	bove is complete a	nd true to the l	pest of my knowledge.
Patient Signature		Date		
Witness		Date		
Medical Record Number:		Registere	ed by:	



WILL COUNTY COMMUNITY HEALTH CENTER

Acknowledgement of Receipt of Joint Notice of Privacy Practices

Our Joint Notice of Privacy Practices ("Notice") provides information about:
1) the privacy rights of our patients; and 2) how we may use and disclose protected health information about our patients. Federal regulations require that we give our patients or their authorized representatives our Notice before signing this acknowledgment.

By signing this for provided our Notice	rm, you are only acknowled ce.	ging that you have been
Patient/Authorized	d Representative Signature	Date
Print Name of Pat	ient/Authorized Representa	ative
Authority of Repre	esentative to Sign for Patien	t (Please check one)
□ Parent	□ Guardian	□ Power of Attorney
□ Other:		

5-2-2019

WILL COUNTY HEALTH DEPARTMENT & WILL COUNTY COMMUNITY HEALTH CENTER CONSENT FOR MEDICAL AND BEHAVIORAL HEALTH EVALUATION AND TREATMENT

Medical Consent: I authorize Will County Health Department & Will County Community Health Center and its medical, dental, behavioral health, and other professional staff members, to provide such health care services and administer such diagnostic and therapeutic procedures and treatments as deemed necessary or advisable in my care. This includes all routine diagnostic tests and procedures, including but not limited to: the administration and/or injection of pharmaceutical products and medications and the withdrawal of blood for laboratory examination. I understand that no guarantees have been made to me as to the results or effectiveness of treatment or examinations performed at Will County Community Health Center. I understand that this consent is valid for up to 1 year and that I may stop services at any time I feel it is necessary.

In the course of treatment, treatment may be provided by a student of nursing, medical assistant, or behavioral health student. I will be informed if a student is working with me and I have the right to decline their services.

[Initials] I do not wish to have students provide my care.

Release of Information: I authorize Will County Health Department/Will County Community Health Center to use and disclose my health information for the following purposes: (1) to provide for, arrange or coordinate my health care treatment; (2) to enable Will County Community Health Center to obtain payment for the services provided; and (3) to permit Will County Community Health Center to carry out ordinary health care and business operations such as quality assurance, service planning, and general administration. I am aware that this authorization to use and disclose information may include information regarding:

- HIV or AIDS
- Mental illness or any mental health disorder
- Family planning, pregnancy

- Alcohol or substance use disorders/Treatment
- Sexually transmitted diseases
- · Genetic tests or genetic diseases

I am aware that Will County Community Health Center may share information with any of my other medical providers for medical treatment or with a third party for financial payment through electronic means.

Assignment of Benefits: I assign to Will County Community Health Center all benefits to which I may be entitled from Medicare, Medicaid, other government agencies, insurance carriers, and other third parties who are financially liable for medical care, behavioral health services, or any other treatment provided by Will County Community Health Center.

Financial Obligations: In the event of non-payment by a third party for which I have provided an assignment of benefits, I am obligated to pay all amounts due for services provided at Will County Community Health Center facilities in accordance with the rates and terms of Will County Community Health Center in effect on the date of service. I also agree that I am responsible for any applicable copayments, coinsurance, or deductibles.

I certify that I have read this form and that I am the patient, or I am duly authorized by the patient, as the patient's representative to execute this form and accept its terms.				
Patient or Responsible Party Name (Print):				
Patient or Responsible Party (Signature):				
Relationship to Patient (if patient is unable to sign):				
Date:	Witness:			
	(Print & Signature)			

Patients under the custody of DCFS must have a "Routine and Ordinary" consent signed by DCFS representative for medical care and a "Mental Health Treatment" consent to receive B.H. services (4-2020)