SIU CARE-A-VAN
Authorization for Medical Care and Registration Form

Please provide the following information in order for your child to utilize the SIU CARE-A-VAN, the mobile health clinic located at Benton High School, Project ECHO and West Frankfort High School. Please print information.

Child's Name _____

Child's Social Security # _____ Birth Date _____

Name of Parent/Guardian _____ Relationship to Student _____

Address _____ City _____ Zip Code _____

Home Phone _____ Cell Phone _____ Parent's Work Phone _____

Child's Physician _____ Physician's Phone _____

Expected graduation year 13 14 15 16 Other _____

If your child's healthcare is covered by private insurance, complete the following:

Person's name on policy and date of birth _____ __/__/__

Relationship to child _____

Social Security # of Policy Holder _____

Place of Employment _____

Insurance Company Name _____

Group # _____ Policy # _____

If your child has a Public Aid Medical Card or All Kids Health Care complete the following:

Child's Recipient number (9 digit #) _____

Does your child have any form of health insurance? _____

If your child does not have insurance, Illinois All Kids Health Coverage information and applications are available upon request.

Does your child have insurance that helps pay for prescriptions? _____

If your child needs medication, what pharmacy do you prefer? _____

List family members/guardians to be contacted in an emergency:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

I understand that the following services will be provided: physical exams, diagnosis and treatment of acute and chronic illness, treatment of minor injuries, prescribing medications, on-site simple lab tests, mental health counseling and referrals. I give my permission for my child to receive medical and mental health care services from the CARE-A-VAN staff. I understand that my child's insurance will be billed for the services and that I will be responsible for co-payments or services not covered. I have the right to refuse services.

This authorization is binding for one year or until written notification of termination is received by this clinic. By signing, I authorize the SIU Care A Van to release my child's immunization record and a copy of any Certificate of Child Health Examination form completed by the SIU Care A Van to Benton High School, Project ECHO, and/or West Frankfort High School and/or I authorize Benton High School, Project ECHO, or West Frankfort High School to release immunization records to the SIU Care A Van.

Parent/Guardian Signature _____ Date _____

SIU HealthCare

Exceptional Medicine. Partners in Care.

Billing/Collection Policy and Procedures & Notice of Privacy Practices Acknowledgement Form

Guidelines for the collection of clinical charges are essential in ensuring that we have the necessary financial resources to serve our patients. Privacy of personal health information is essential to assure your trust. Our policies in these two areas are listed below and in the Notice of Privacy Practices given to all patients.

MEDICARE AND OTHER INSURANCE CLAIM FILING

If you are a Medicare patient and have provided us with your Medicare billing information, we will file your claim automatically. If you have other insurance and have provided us with the appropriate name and address of your carrier, the SIU HealthCare (SIU HC) Business Office will provide your insurance carrier with the necessary forms to process your claim.

If we do not have this information, you will be responsible for your bill. If you need additional assistance, the Business Office can provide any other necessary forms once your bill has been paid.

BILLING STATEMENTS

After your insurance has adjudicated your claim, you will receive an itemized **statement** listing the amount owed by you along with your itemized account charges, receipts, and credits. This statement combines services for all SIU HC providers.

PAYMENT

All charges are due and payable at time of service or upon receipt of the initial statement.

Payments can be made by cash, check, MasterCard, Discover Card or VISA. Checks should be made **payable to SIU HealthCare or SIU HC**. In making payment, regardless of source, please include the lower portion of your statement to ensure that your payment is credited properly.

FINANCE CHARGES

At the current time we do not typically assess a **Finance Charge**. However, we reserve the right to charge one if any part of your account balance is unpaid **90 Days** after the initial billing. The Finance Charge will be an amount equal to a periodic rate of 1% Per Month (Annual Percentage Rate of 12%) applied to any part of your account balance 90 Days and Older. The **Minimum Finance Charge** will be **Fifty Cents ($.50) Per Month.**

YOUR BILLING RIGHTS

This notice contains important information about your billing rights and our responsibilities under the Fair Credit Billing Act in case of errors or questions about your bill.

NOTIFY US IN CASE OF ERRORS OR QUESTIONS ABOUT YOUR BILL

If you think your bill is wrong or you need more information about a transaction on your bill, write us on a separate sheet at the address listed on your statement. Write to us as soon as possible. We must hear from you no later than **60 Days** after we sent you the first bill.

YOUR RIGHTS AND OUR RESPONSIBILITIES AFTER WE RECEIVE YOUR WRITTEN NOTICE

We must acknowledge your letter within **30 Days**, unless we have corrected the error by then. Within **90 Days**, we must either correct the error or explain why we believe the bill was correct.

After we receive your letter, we cannot try to collect any amount you question until we have corrected or explained the bill. We can continue to bill you for the amount in question. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question.

After we have resolved the amount in question, if you fail to pay the amount that we think you owe, we may report you as delinquent. However, if our explanation does not satisfy you and you write to us within **10 Days** telling us that you still refuse to pay, we must tell anyone we report you to that you have a question about your bill. We must tell you the name of anyone we report you to. We must tell anyone we report you to that the matter has been settled between us when it finally is.

If we don't follow these rules including time limits, you may request a credit on the first fifty ($50.00) dollars of the questioned amount, even if your bill was correct.

* *

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment of insurance benefits otherwise payable to me, directly to SIU HC as the provider of services rendered not to exceed the provider's charges. I understand that I am financially responsible for charges not covered by this authorization. It is further agreed that any credit balance resulting from overpayment may be applied to other balances.

* *

RELEASE OF MEDICAL INFORMATION

I hereby authorize SIU HC and/or Southern Illinois University School of Medicine, upon the authority of this certificate or a photostatic copy thereof, to use and disclose my **protected health information** for the purposes of **treatment, payment and health care operations**. To the extent applicable, I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that I have the right to revoke this authorization at any time. If I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I hereby acknowledge that I received the Notice of Privacy Practices of SIU HC and Southern Illinois University School of Medicine, which sets forth the ways in which my **protected health information** may be used or disclosed and outlines my rights with respect to such information.

Signature _____ Date _____ SIU Medical Record Number _____ Ver. 07/2012