Healthcare Centers of Morris Hospital
Registration Form

Please complete front and back

Date: _____ PCP: _____

Last Name: _____ **First Name:** _____ **MI:** _____

Is this your legal name? ☐ Yes ☐ No If not, what is your legal name? _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____)_____ Cell: (____) _____ Work: (____)_____

Patient Portal Consent ☐ Yes ☐ No **Email Address:** _____

Date of Birth: ____/____/_____ **Sex:** ☐ M ☐ F **Social Security Number:** _____-____-_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Partner

Preferred Language: ☐ English ☐ Spanish ☐ Russian ☐ Other

Race: ☐ White ☐ Black/African American ☐ Hispanic ☐ Asian ☐ Native Hawaiian
☐ American Indian/Alaska Native ☐ Other ☐ Refused to Report

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Refused to Report

Employer: _____ Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Employment Status: ☐ FT ☐ PT ☐ Not Employed **Are you a Student?** If yes, ☐ FT ☐ PT

Preferred Pharmacy: _____ Pharmacy Phone #: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

☐ **Release test results only to me**
☐ **Leave message on voicemail to call the office**
☐ **Leave message on voicemail with test results**
☐ **Leave message or test results with family member**

Specify Name: _____ **Phone: (____)** _____

I have a legal document indicating a Medical Power of Attorney, Living Will, and/or DNR status **(if yes, please provide the office with a copy for your records)**

☐ Medical Power of Attorney ☐ Do Not Resuscitate ☐ Living Will ☐ Not applicable ☐ None

Emergency Contact

Last Name: _____ **First Name:** _____ **MI:** _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Date of Birth:_____ Relationship to Patient:_____

Healthcare Centers of Morris Hospital
Registration Form

Responsible Party (person responsible for bill)

☐ **Same as Patient**

Last Name: _____ **First Name:** _____ **MI:**

Address: _____ City: _____ State: _____ Zip:

Home Phone: (____)_____ Work Phone: (____) _____ Cell Phone: (____) _____

Relationship to Patient: _____

Date of Birth: ____/____/_____ Sex: ☐ M ☐ F Social Security Number: _____-____-_____

Employer Name: _____ Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Information

Primary Insurance Company: _____

Subscriber #: _____ Group #: _____

Subscriber Name: _____ ☐ Same as Patient

Is this person a patient here? ☐ Yes ☐ No

Date of Birth: ___/___/_____ Relationship to Patient _____ SSN#:_____

Name of Employer:_____ Phone: (____)_____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance Company: _____

Subscriber #: _____ Group #: _____

Subscriber Name: _____ ☐ Same as Patient

Is this person a patient here? ☐ Yes ☐ No

Date of Birth: ___/___/_____ Relationship to Patient _____ SSN#:_____

Name of Employer:_____ Phone: (____)_____

Address: _____ City: _____ State: _____ Zip: _____

Tertiary Insurance Company: _____

Subscriber #: _____ Group #: _____

Subscriber Name: _____ ☐ Same as Patient

Is this person a patient here? ☐ Yes ☐ No

Date of Birth: ___/___/_____ Relationship to Patient _____ SSN#:_____

Name of Employer:_____ Phone: (____)_____

Address: _____ City: _____ State: _____ Zip:_____

MORRIS HOSPITAL
ALLERGY SPECIALISTS

MEDICAL & FAMILY HISTORY FORM

NAME: _____ **DATE OF BIRTH**: _____ **TODAY'S DATE**: _____

What is the reason for your visit today? _____

Current Medications:

Name	Strength	Frequency

Past Medical History:

□ Anemia/blood disorder □ Anxiety □ Arthritis □ Asthma □ Autoimmune □ Back problems □ Cancer: _____
□ Cataracts □ Colitis □ Depression □ Diabetes □ Emphysema □ Glaucoma □ Gynecological problems _____
□ Heart Disease □ Heart Murmur □ Heartburn/reflux □ High Blood Pressure □ High Cholesterol □ Hyperactivity
□ Irritable Bowel Syndrome □ Jaundice □ Kidney/bladder disease □ Liver disease/hepatitis □ Loss of Balance
□ Loss of hearing □ Migraines/Headaches □ Osteoporosis □ Peptic ulcer □ Pneumonia □ Rashes □ Seizures
□ Thyroid disease □ Other: _____

Allergies (list all known allergies including medication, food, animal, dye, latex, stinging insects, seasonal, etc):

Allergy	Reaction	Allergy	Reaction

Surgical/Procedure History:

Surgery/Procedure	Date	Surgery/Procedure	Date

Hospitalization History:

Reason	Date	Reason	Date

Family History:

Condition	Mother	Father	Maternal Grandparent(s)	Paternal Grandparent(s)	Sibling(s)
Healthy/Alive					
Deceased					
Allergic rhinitis					
Arthritis					
Asthma					
Bleeding problems					
Cancer (specify type)					
Chronic sinusitis					
Diabetes					
Eczema/Dermatitis					
Emphysema					
Food Allergy					
Hay Fever					
Heart Disease					
High Blood Pressure					
Immunodeficiency					
Nasal Polyps					
Pet allergies					
Recurrent infections					
Sleep Apnea					
Stinging insect allergy					
Thyroid disorder					
Urticaria/Hives					
Other					

Social History:

Alcohol use: □ never □ sometimes □ socially □ number of drinks per week: _____

Occupation: _____

Recreational drug use: □ yes □ no □ which ones and how often: _____

Smoking (exposed to second hand smoke): □ yes □ no

Tobacco use: □ never □ current every day smoker □ current someday smoker □ former smoker

Triggers (Please check all items or triggers that you feel make your symptoms worse):

Outdoor:

□ barn exposure □ being around flowers/plants □ bird □ bonfire □ burning leaves □ fall □ farm area □ fireplace
□ grass □ hay □ hornet □ horses □ lakes/retention ponds □ mold/mildew □ mosquito bite □ mowing grass
□ outdoor smoke □ pine trees □ pollen □ raking leaves □ spider bite □ spring □ stinging insect bite □ summer
□ swimming pool □ trees □ wasp □ weeds □ winter

Indoor:

□ air-conditioning □ aromatic wood/incense □ basement □ bedroom □ carpet □ cat □ comforter □ dog
□ fabric/upholstery furniture □ futon □ guinea pig □ hamster □ home □ house cleaning □ house dust □ mattress
□ other animals □ school □ sofa □ stuffed animals □ vacuuming □ ventilation □ work environment

Chemical/Clothing:

□ adhesive □ aerosol products □ air freshener □ blanket □ bleach/chlorinated products □ cashmere □ chalk
□ detergents □ down coat □ dry-cleaned garments □ fabric dyes/coloring □ feather pillows/bedding □ fertilizer
□ fiberglass □ glue □ household cleaners □ industrial solvents □ insecticide □ new clothing □ nylon □ old clothing
□ paint fumes/thinners □ paper boxes □ polyester □ rubber □ sawdust □ shoes □ socks □ spandex
□ tight garments □ undergarments □ waist/elastic band □ wool

Direct Contact:

□ acrylic nails □ alcohol based body/facial products □ anti-aging products □ bath oils □ body soaps □ bronze
□ cobalt □ cosmetics □ deodorants □ dishwashing soap □ eye cream □ fabric softener/sheets □ face wash
□ hair dye □ jewelry □ latex □ laundry detergent □ leather belt □ lotions □ metal wrist watch □ metallic implants
□ mouthwash □ nail polish □ nail polish remover □ newspaper □ nickel □ perfumes □ scented hygiene products
□ shampoo/conditioner □ shaving cream/gel □ silver □ tin □ titanium □ toothpaste

Non-allergy related:

□ anger □ cold air □ cold beverage □ cold object □ cold water □ cooking fumes/odors □ direct pressure on skin
□ dry air □ emotional stress □ exercise □ gardening products/sprays □ going from hot to cold temperature □ heat
□ hot beverage/foods □ hot water/shower □ humidity □ minor trauma to skin □ pollution □ prolonged sitting
□ rain □ rubbing skin □ sauna □ sleeping on back □ spicy foods □ sweating □ tobacco smoke □ travelling
□ vapors □ vibration □ while cooking □ while eating

Food:

□ aged cheese □ banana □ beef □ beer □ berries □ bread □ buckwheat □ caffeine products □ cakes □ celery
□ cereal □ cheese □ chocolate □ cider □ citrus □ coffee □ cooking oils □ corn □ corn syrup □ cured meats
□ dried fruit □ eggs □ fish □ food dyes □ fresh fruit □ fresh vegetables □ frozen food products □ gluten □ ham
□ herbs □ ketchup □ lamb □ malic acid □ melons □ milk □ mint □ mixed alcoholic beverages □ MSG □ nuts
□ oats □ peanut □ pears □ pickles □ pork □ potatoes □ processed meats □ rye □ sausage □ shellfish □ soy
□ spices □ starch □ tea □ tomatoes □ turkey □ vinegar □ wheat □ wine

Hormonal (women only):

□ hives during pregnancy □ hives during menstrual cycle □ irregular periods

□ **I am not experiencing any of the above symptoms at this time**

Please explain any of the above checked triggers in detail (if needed) or please include any triggers not mentioned above which may be causing a problem for you: _____

_____

Allergy History:

Have you been evaluated by an allergist in the past? □ yes □ no

Have you ever been diagnosed with any of the following conditions: □ yes (check all that apply below) □ no

□ allergic reaction □ allergy rhinitis/allergies seasonal □ anaphylaxis (life-threatening allergy reaction)
□ angioedema (swelling of the face, lips, mouth, hands or feet) □ asthma □ celiac disease □ chronic hives
□ contact dermatitis □ dermatographism (skin writing disease) □ drug allergy □ eczema/atopic dermatitis
□ exercise-induced asthma □ food allergies □ food intolerance □ immunodeficiency □ itchy skin
□ lactose intolerance □ low antibody levels □ non-allergic rhinitis or weather induced allergies □ pet allergies
□ year-round allergies □ other: _____

Have you had prior testing? □ yes □ no

□ antibiotic testing □ food allergy testing □ insect sting testing □ patch testing □ PFT or spirometry testing

□ RAST/immunocap testing (blood test for allergies) □ skin testing

Please explain any important findings from above prior testing: _____

Have you had any prior treatment? □ yes □ no

□ avoidance measures □ dustmite control measures □ eczema treatment □ epipen/epinephrine auto-injector

□ food allergy treatment □ hives workup and treatment □ OTC/prescription medication □ SLIT (oral allergy drops)

Have you received allergy injections in the past? □ yes □ no If yes, when: _____

Result of allergy injections: □ allergic reaction to allergy injections □ symptoms alleviated □ symptoms not alleviated

Do you have any diagnosed food allergies? □ yes □ no

If yes, please list all foods you are allergic to and the reaction you had to that particular food:

Food: _____ Reaction: _____

Food: _____ Reaction: _____

Food: _____ Reaction: _____

Food: _____ Reaction: _____

Do you avoid any foods? □ yes □ no

If yes, please list any foods you are avoiding: _____

Pediatric Allergy History (for all ages 6-18):

History of any of the following: □ yes □ no

□ chronic congestion or runny nose □ colic □ croup □ difficulty with feeding □ eczema □ failure to thrive

□ food allergies □ hay fever □ history of FPIES (vomiting/bloody stools) □ low birth weight □ milk intolerance

□ pneumonia(s) □ premature birth □ recurrent viral infections and colds □ reflux □ RSV infection □ wheezing

Were you breastfed? □ yes □ no if yes, how long: _____

Were you formula fed? □ yes □ no if yes, how long: _____

Have you had reactions or did not tolerate immunizations? □ yes □ no

Are you up to date on immunizations? □ yes □ no

Environmental History:

How long have you lived in your residence? □ < 1 year □ 1-5 years □ 6-10 years □ > 10 years

Type of home? □ house (basement) □ garden-level apartment/duplex □ single family home – own

□ single family home – rent □ townhouse □ upper-level apartment/duplex

Age of home? □ < 1 year □ 1-5 years □ 6-10 years □ 10-20 years □ > 20 years

Location of home? □ city □ rural area □ suburbs

Do you have a basement? □ yes □ no

□ crawl space □ dry □ finished □ unfinished □ seepage or leak □ wet or musty

Past flooding in the home? □ yes □ no □ unknown

Type of heating in home? □ central forced air □ hot air □ hot water (baseboard) □ radiator (steam)

□ solar □ space/electric heater

Type of air-conditioning? □ none □ central A/C □ window unit □ other _____

Change air filters? □ every month □ every 3 months □ every 6 months □ never □ unknown

Type of filters? □ HEPA □ 3M □ 2M □ unknown

Do you keep your windows open in warmer months? □ yes □ no

Type of home ventilation? □ air cleaner □ ceiling fans □ dehumidifier □ HEPA filters □ humidifier

□ wood/coal stove or fireplace

Number of pets? □ 1 □ 2 □ 3 or more

□ cats □ dogs □ birds □ guinea pigs □ hamsters □ rabbits □ other _____

Do pets sleep in your bedroom? □ yes □ no

Are there any tobacco smokers in the home? □ yes □ no

Is your bedroom in the basement? □ yes □ no

Do you use allergy-proof encasing for your pillows and/or comforter? □ yes □ no □ unknown

Do you use feather pillows and/or comforter? □ yes □ no □ unknown

Type of flooring in your bedroom? □ animal skin □ area rug □ bare floor □ wall to wall carpet

Age of carpeting in bedroom? □ < 1 year □ 1-5 years □ 6-10 years □ > 10 years □ unknown

Carpeting in the living room? □ yes □ no

Age of mattress? □ < 1 year □ 1-5 years □ 6-10 years □ > 10 years □ unknown

What is inside your mattress? □ cotton □ horse hair □ foam □ unknown

Problems with roaches or mice in your home? □ yes □ no □ unknown

Problems with water leaks or mold contamination in your home? □ yes □ no □ unknown

Is your residence excessively humid? □ yes □ no □ unknown

Prior Lab Work, Testing or Consultations:

Have you had any prior autoimmune workup checking for rheumatologic conditions in the past? □ yes □ no

Have you had any prior testing/imaging: □ yes □ no

□ chest xray □ CT of chest □ CT of ear □ CT of head □ CT of neck □ CT of sinuses □ endoscopy with biopsy

□ MRI of ear □ MRI of head □ MRI of neck □ MRI of sinuses □ prior sinus surgeries □ rhinoscope □ skin biopsy

Have you had any prior consultations: □ yes □ no

□ ENT □ dermatology □ gastroenterology □ pulmonary □ rheumatology

Please describe all important lab, imaging and consultation findings from above: _____

_____

Nasal or Sinus Concerns (if no concerns, please skip to the next section):

Do you have the following nasal or sinus symptoms consistently? □ yes (check all that apply below) □ no

□ burning in mouth □ clear, thin/think or white/yellow/green mucous □ congestion □ dark circles under eyes

□ dry mouth □ dry/gritty eyes □ ear pain □ ear plugging □ ear ringing □ hayfever □ headache □ hoarseness

□ itchy mouth or lips □ migraines □ nasal polyps □ nasal/sinus pressure □ pain in throat □ postnasal drip

□ red eyes □ runny nose □ scratchy throat □ sneezing □ sores in mouth □ tearing of eyes □ watery eyes

How long have you been having symptoms? _____

Describe your symptoms:

□ no pattern noticed □ ongoing for #_____ days, months, years □ daily □ intermittent □ worse in morning

□ worse in afternoon □ worse in evening □ worst at night □ specific pattern, please describe: _____

What have you tried as treatment for nasal or sinus problems? _____

Did the treatment work? □ yes □ no

Please list all over the counter and prescription allergy and sinus medications taken: _____

_____

Are there any other important details about your nasal or sinus problems that you think we should know? _____

_____

Asthma or Breathing Concerns (if no concerns, please skip to the next section):

At what age were you first diagnosed with asthma? _____

How was the asthma diagnosed? _____ □ unknown

Do you have the following breathing or asthma symptoms consistently? □ yes (check all that apply) □ no

□ anxiety □ burning in chest □ chest pain with exhalation □ chest pain with inhalation □ chest tightness
□ cold hands and feet □ cyanosis □ cough – dry, hacking □ cough – productive □ fatigue □ feeling of warmth
□ hyperventilation □ mucous production □ nervousness □ numbness and tingling in hands or feet □ pain in back
□ pain in ribs □ pain in shoulder □ shortness of breath □ wheezing – persistent, intermittent

Describe all that apply to the pattern and duration of your asthma or breathing problems:

□ no pattern found □ rare and mild □ getting worse □ about the same □ at rest □ exertion □ morning
□ afternoon □ evening □ throughout the day □ intermittent □ continual □ 1-2 times a week
□ more than twice a week □ few times a month □ wakes patient up at least once a week at night
□ wakes up patient more than once at night □ spring □ summer □ fall □ winter □ year round

How often do your symptoms occur?

□ # _____ per week □ # of _____nighttime awakenings □ # _____ per month

How many times a year do the following infections make your asthma or breathing worse?

□ # of bronchitis _____ □ # of pneumonias _____ □ # of recurrent URIs _____ □ # of sinus infections _____

How many urgent care/ER visits have you had for asthma or breathing trouble in the past year? _____

How many oral or IV steroid courses for asthma in past year? _____

Were the symptoms alleviated with steroids? □ yes □ no

Number of days missed from work or school in past year? _____

Number of infections triggering asthma in past year? _____

Do you have an Asthma Action Plan given by a health care provider in the past year? □ yes □ no

When was your last PFT or spirometry? _____

When was your last Chest X-ray or CT of chest? _____

Have you ever been treated with inhalers? □ yes □ no

What are you using to treat your asthma or breathing symptoms at this time? _____

Is the treatment working? □ yes □ no

Recurrent Infections (if you have had 9-12 diagnosed infections in the past year then please complete this section)

How long have you been getting recurring infections? _____

How many days have you missed from work or school due to recurrent infections in the past year? _____

What symptoms do you have with these recurrent infections?

□ anemia □ bruising □ chest tightness □ chronic congestion □ chronic runny nose □ clear mucous drainage
□ cold or heat intolerance □ dry cough □ ear pain and ringing □ headaches □ itchy eyes □ loss of appetite
□ nasal polyps □ night sweats □ ocular tearing □ productive cough □ purple skin rash □ shortness of breath
□ sore throat □ swollen eyes □ weight loss □ wheezing □ yellow or green mucous

What types of recurrent infections have you had in the past years?

□ acute bronchitis □ acute ear infection □ acute sinusitis □ bladder infection □ canker sores
□ chronic recurrent ear infections □ chronic sinusitis □ chronic UTIs □ dental infection □ fever blisters
□ foot sore/ulcers □ fungal pneumonia □ fungal sinusitis □ gallbladder infection □ gastric ulcer
□ gastroenteritis □ h. pylori infection □ impetigo □ influenza □ jaundice □ liver infection of abscess
□ lyme disease □ meningitis □ mono □ nail infection □ open sores/wounds □ parasitic infection □ pharyngitis
□ pneumonia □ recurrent bronchitis □ recurrent chrohn's disease □ recurrent fungal infections of skin and nails
□ recurrent HSV infection □ recurrent Lyme disease □ recurrent skin ulcers □ recurrent strep
□ recurrent tonsillitis □ recurrent ulcerative colitis □ recurrent URIs □ skin abscess □ skin infection
□ stomach flu □ thrush □ tinea corpis □ uncontrolled diabetes □ UTI □ vaginal infection □ viral hepatitis
□ viral URIs □ west nile virus □ yeast infection

Have you done the following activities in the past 1-2 years before your infections started? □ yes □ no

□ camping □ drinking unpasteurized milk products □ drinking water from fresh stream

□ food consumption at picnic □ travel outside the country □ wooded areas

Have you received any of the following treatment for your immune system? □ yes □ no

□ abscess drainage □ allergy injections □ antibiotics □ oral steroids □ IV steroids □ IVIG □ sinus surgery

List the name of all medications you have tried for recurrent infections (include all antibiotics): _____

_____

Are you on IVIG treatment? □ yes □ no if yes, what is the name of the medication and how long were you treated?

Did the treatment work? □ yes □ no

Allergic Reaction, Swelling, and Skin Rashes (if no concerns, please skip to the next section):

Are you having any of the current skin problems or reactions? □ yes □ no

□ anaphylactic/severe allergic reaction □ chronic itching □ eczema/atopic dermatitis □ hives □ rash □ swelling

At what age were you first diagnosed with skin problem or allergic reaction(s)? _____

Describe the characteristics of the current skin reaction(s) or rash: _____

Where is the skin rash or allergic reaction occurring?

□ abdomen □ all over body □ ankle □ arms □ around eyes □ back □ chest □ eyebrow area □ face □ feet

□ fingers □ groin □ hands □ legs □ lips □ neck □ on eyelids □ spreading everywhere □ throat □ trunk

□ wrist

Describe the pattern of the allergic reaction:

□ no pattern found □ getting worse □ getting better □ intermittent □ lasts 12 hours □ lasts 24 hours

□ lasts 2-6 hours □ lasts greater than 6 hours □ lasts less than 1 hour □ lasts more than 24 hours

□ occurring at night □ occurring in the afternoon □ occurring in the evening □ occurring in the morning

□ occurring once a day □ occurring through the day □ present all the time □ resolved □ same □ sporadic

□ wakes me up at night

Did food avoidance alleviate skin condition? □ yes □ no if yes, please list foods: _____

How many ER/urgent care visits have you had for skin rash or allergic reactions in the past 6 months? _____

Have you used any of the following medications on a regular basis in past year? □ yes □ no

□ antidepressant □ arthritis medication □ aspirin/nonsteroidal medication (motrin/ibuprofen) □ biologics

□ bioxin □ blood pressure medication □ cephalosporin □ cholesterol medication □ cortisone

□ cough medication □ decongestants □ diet pills □ digitalis □ diuretics □ erythromycin □ floroquinolone

□ homeopathic/herbal supplements □ hormones □ insulin □ IV contrast media □ laxatives □ mouth washes

□ muscle relaxants □ narcotics □ oral contraceptives □ PCN □ sedatives □ seizure medication □ sulfa

□ suppositories □ tetracycline □ thyroid medication □ tonic or quinine □ tranquilizers □ vaccination

□ vitamins □ water pill □ zithromycin □ other: _____

Do you think a particular medication is causing your symptoms? □ yes □ no if yes, list medication: _____

Were any of your current medication dosages changed or increased in past 6 months? □ yes □ no if yes, list medication _____

Please list all treatments tried for your skin rash or allergic reaction:

□ antibiotics □ avoidance of triggers □ Benadryl liquid □ Benadryl oral □ cetirizine/Zyrtec

□ changed all body products □ changed detergent brand □ Epinephrine given in ER □ Epipen/Auvi-Q for home

□ fexofenodine/allegra □ fragrance-free detergents □ hypoallergenic soaps □ itching □ IV steroids were given

□ loratidine/Claritin □ lotions □ moisturizers □ oral steroids □ OTC/prescription creams/ointments

□ pepcid/famotidine □ shampoos □ zantac/rantidine □ other: _____

Did the treatment work? □ yes □ no

Food Reactions (if no concerns, please skip to the next section):

List all foods which you already have a confirmed diagnosis of a food allergy and describe the reaction you had: _____

_____

Do you have the following symptoms from Food Ingestion consistently? □ yes □ no

□ abdominal pain □ anaphylaxis □ bloating □ blood in stool □ burning in mouth □ chest tightness
□ congestion □ constipation □ coughing □ diarrhea □ diffuse hives □ dizziness □ eczema/atopic dermatitis
□ flushing □ gas □ headaches □ itchy mouth/lips □ joint pain □ localized hives □ loose stools
□ loss of consciousness □ migraines □ muscle stiffness/pain □ nausea □ numbness/tingling □ rashes
□ runny nose □ shortness of breath □ skin itching □ sneezing □ sores in mouth □ stomach cramping
□ swelling □ vomiting □ watery/itchy eyes □ wheezing

Duration/pattern of symptoms: □ ___ # of days □ ___ # of months □ ___# of years □ daily □ intermittent

□ worse in morning □ worse in afternoon □ worse in evening □ worse at night □ no pattern
□ specific pattern: _____

Did avoidance of certain foods above alleviate yours symptoms? □ yes □ no □ not sure

Do you have a milk allergy or are you lactose intolerant? □ yes □ no if yes, at what age did it occur? _____

Do you have diagnosed gluten intolerance? □ yes □ no if yes, at what age did it occur? _____

Please list all treatments tried for your food allergy/intolerance:

□ no treatment in the past □ albuterol □ antihistamine – as needed □ antihistamine – daily □ Epinephrine in ER
□ Epipen/Auvi-Q at home □ IV steroids □ medication along with food avoidance □ moisturizers for skin
□ oral immunotherapy (SLIT) □ oral steroids □ steroid creams/ointments □ steroid inhaler

Did the treatment work? □ yes □ no

Are there any other important details that you think we should know? _____

_____

Stinging Insect Allergy (if no concerns, please skip to the next section):

Have you ever been stung by an insect? □ yes □ no

□ bee □ fire ant □ hornet □ mosquito □ spider □ wasp □ yellow jacket □ unknown

Did you have a reaction? □ yes (check all that apply) □ no

□ anaphylactic shock □ asthma symptoms □ bloating □ chest tightness □ diarrhea □ eye swelling
□ facial swelling □ flushing □ hives all over □ itching all over □ large but localized reaction □ lip swelling
□ localized minor rash □ loss consciousness □ low blood pressure □ mild redness □ mild swelling □ nausea
□ persistent coughing □ shortness of breath □ tongue swelling □ vomiting □ wheezing

How did you treat the reaction?

□ antihistamine or Benedryl □ epinephrine given in ER □ ER/urgent care visit(s) □ Epinephrine/Auvi-Q at home
□ nebulizer treatment □ topical Benadryl □ topical steroid cream/ointment □ O2 given

List any important details about the reaction: _____

Review of Symptoms:

General:	□ fatigue □ fever □ loss of appetite □ night sweats □ weight gain □ weight loss
Eyes:	□ blurry vision □ cataracts □ double vision □ dry eyes □ eye irritation □ eye redness
	□ eye pain □ glaucoma □ itchy eyes □ swelling around eyes/eyelids □ watery eyes
Ear, Nose, Throat: (if	□ congestion □ ear pain □ ear plugging □ ear ringing □ nose bleeds
not addressed above)	□ poor sense of smell □ post-nasal drip □ runny nose □ sinus pain □ sneezing □ sore throat
Cardiology:	□ chest pain □ dizziness □ increased heart rate □ leg swelling □ murmurs
Respiratory:	□ chest tightness □ cough □ excessive sputum
	□ pain in ribs with movement or taking a breath □ shortness of breath □ wheezing

Gastrointestinal:	□ jaundice □ abdominal pain □ bloating □ blood in stool □ constipation □ diarrhea □ difficulty swallowing □ increased gas □ heartburn □ vomiting
Urology:	□ blood in urine □ pain with urination □ urinary frequency □ urinary urgency
Female Reproductive:	□ hot flashes □ irregular menses □ pelvic pain
Musculoskeletal:	□ joint pain □ joint stiffness □ joint swelling □ muscle aches □ muscle weakness
Dermatology: (if not addressed above)	□ unusual birth marks □ dry or sensitive skin □ hair loss □ itching □ lumps □ rash □ skin ulcer □ swelling □ hives □ rash appears with scratching of skin
Endocrinology:	□ enlarged thyroid □ brittle hair and nails □ fainting □ cold intolerance □ excessive sweating □ excessive thirst □ heat intolerance
Hematology:	□ masses or tumors □ easy bleeding □ easy bruising □ enlarged lymph nodes
Neurology:	□ headache □ loss of consciousness □ paralysis □ seizures □ tingling/numbness □ muscle weakness □ migraines
Psychology:	□ panic attacks □ anxiety □ depression

□ **I am not experiencing any of the above symptoms at this time**

Please also let us know of any information that you feel is worth knowing regarding your current symptoms and medical history that we did not ask in this form: _____

_____

I have provided all accurate information regarding my current symptoms and medical health to the best of my ability for my visit to the Allergist

Patient signature: _____ **Date:** _____

MORRIS HOSPITAL
ALLERGY SPECIALISTS

Beta Blocker Screening Form

The medications listed below are "beta blockers", commonly used to treat high blood pressure, angina (chest pain), irregular heart rhythms, and migraine headaches.

Please place a check mark if you are currently taking any of the medications listed below:

Oral Medications

____ Betapace (Sotalol)
____ Blocadren (Timolol)
____ Bystolic (Nebivolol)
____ Cartrol (Carteolol)
____ Coreg (Carvedilol)
____ Corzide, Corgard (Nadolol)
____ Inderal, Innopran XL (Propranolol)
____ Inderide (Propranolol)
____ Kerlone (Betaxolol)
____ Levalol (Penbutolol)
____ Lopressor (Metoprolol)
____ Normodyne, Normozide (Labetalol)
____ Sectral (Acebutolol)
____ Tenoretic (Atenolol)
____ Tenormin (Atenolol)
____ Other: _____

____ Timolide (Timolol)
____ Toprol3XL, Toprol (Metoprolol)
____ Trandate (Labetalol)
____ Visken (Pindolol)
____ Zebeta (Bisoprolol)
____ Ziac (Bisoprolol)
____ Breviloc (Esmolol) – IV use

Eye Drop Section

____ Betopic (Betaxolol)
____ Betagan (Levobunolol)
____ Betimol (Timolol)
____ Corsopt (Timolol)
____ Istalol (Timolol)
____ Ocupress (Carteolol)
____ Optipranolol (Metipranolol)
____ Timoptic (Timolol)

If you should be started on any new medication(s) by your physician, please notify either our allergy nurse or physician in our office of any changes.

_____ I am currently on the medication(s) listed above

_____ I am currently NOT on any medication(s) list above

Patient Name: _____ Date: _____

Signature: _____

HEALTHCARE CENTERS OF MORRIS HOSPITAL
CONSENT FORM AND AGREEMENT

1. I, _____, for myself (or on behalf of_____) believe that I have a condition requiring care, hereby voluntarily consent to such care. I consent to medical treatment, and care, or other Healthcare Centers of Morris Hospital services including nursing care rendered me under general or special instructions of attending, consulting, or other physicians. This consent includes but is not limited to, the administration of fluids, and medications.

2. **I UNDERSTAND…**

   a. The practice of medicine is not an exact science. I acknowledge that no guarantees have been made to me as to the diagnosis or result of examination or treatment in the Healthcare Centers of Morris Hospital.

   b. That some physicians on staff at Morris Hospital and Healthcare Centers (i.e. Radiologists, Cardiologists, Emergency, Pain Management, Wound Care) are not employees or agents of Morris Hospital and Healthcare Centers, but are instead independent medical practitioners who have been permitted to use Morris Hospital and Healthcare Center's facilities and to exercise their independent medical judgment in the care and treatment of their patients. However, Morris Hospital and Healthcare Centers do employ physicians practicing at the Healthcare Centers of Morris Hospital. I further acknowledge that the employment or agency status of physicians who treat me is not relevant to my selection of Morris Hospital for my care. I also understand that I will receive, and am solely responsible for payment of, a separate bill from each of these physicians, or groups of physicians, for care, treatment, or services provided. These physicians may or may not participate in managed care contracts.

      (By initialing, I acknowledge that I have read and understand the above paragraph) Initials: _____

   c. I have been informed that this facility serves only as a lab draw station for Morris Hospital. Morris Hospital processes all specimens sent from this facility and will be billing my insurance for the lab work done in this office. I have also been informed that a hospital deductible may need to be met, according to the terms of my insurance plan. I understand that I may receive a bill from Morris Hospital, separate from my office visit bill, for the balance remaining on my lab charges after insurance has been billed.

   d. That hospital authorized nursing and allied health students accompany and sometimes participate with physician(s) and hospital staff in the delivery of, as well as the observation of care.

   e. That any authorization or consent that I have given may be cancelled or revoked by me in writing at any time.

   f. That I have a right to express a concern or grievance regarding any quality of care issue either informally or formally through the patient grievance mechanism established by the Healthcare Centers.

3. I agree that I will not hold Morris Hospital and Healthcare Centers liable for the loss or damage to any money, jewelry, glasses, dentures, documents, fur coats, or other articles, goods, or property of any kind and description. I agree to inform the nursing staff of any valuables in my possession.

RELEASE OF INFORMATION

4. I authorize the Healthcare Centers of Morris Hospital to retain, preserve and use for scientific or teaching purposes or to dispose of any specimen or tissue taken from my body during my Healthcare Center office visit.

5. In the event I am transferred to another health care facility or physician office, I authorize the Healthcare Centers of Morris Hospital to release information and/or copies of my medical record, or portions thereof, to such other health care facility and/or physician office in the event of such transfer. I further authorize the facility and any physicians to which I am transferred to provide information to Healthcare Centers of Morris Hospital upon request of the hospital/physician regarding the care, condition and treatment of myself (and/or my child).

6. I authorize the use of my medical records for quality assurance and/or risk management purposes. I further authorize any health care provider, including my physician and consulting physicians, to provide information to the Healthcare Centers of Morris Hospital upon request concerning my care, condition, and treatment.

7. In the event a health care provider sustains exposure to my blood and/or fluids, I give permission for a sample of my blood to be drawn and tested for infectious disease of any nature and description.

8. **PAYMENT FOR SERVICES AND RELEASE OF INFORMATION**

   I authorize the Healthcare Centers of Morris Hospital to release and/or send any medical information deemed by it to be necessary for the processing and payment of my Healthcare Center bills to any insurance company or other third party payor who is or may be responsible for paying any part of my medical treatment. **I understand that this information may include the diagnosis of and treatment for both mental illness and drug and alcohol abuse.**

   I understand that this authorization is furnished to enable the Healthcare Centers on behalf of itself, the physicians for whom the Healthcare Centers are authorized to bill, and also physicians who bill on behalf of themselves, and myself to obtain or attempt to obtain proceeds, benefits, or amounts due to me or to members of my family from insurance companies or third party payors due to my treatment and office visit. In consideration of the Healthcare Centers, it's agents, servants, employees, and attorneys from all responsibilities and/or liabilities incidental to their release of my office records and other information. I further authorize the Healthcare Centers to release and/or send copies of my records or portions thereof to my referring physicians and to physicians on the staff of the hospital or other hospitals which were consulted in regard to my treatment, for their use in releasing information to third parties for the purpose of billing and collection amounts due to them for services rendered.

   This release includes the results of any blood test that may be performed to determine the presence of the Human Immunodeficiency Virus (causative agent of AIDS)

9. **"Important Message from Medicare":** My signature only acknowledges my receipt of this "Important Message from Medicare" from Healthcare Centers of Morris Hospital and does not waive any of my rights to request a review or make me liable for any payment.

10. **Assignment of insurance benefits**: In the event I am entitled to benefits arising out of any policy insuring me, those benefits are hereby assigned to the Healthcare Center's of Morris Hospital for application on my bill. Financial agreement: It is understood, whether I sign as agent, or as patient, or as guarantor, that I am directly responsible and will pay for service rendered and not paid by insurance. The Healthcare Centers of Morris Hospital may obtain a consumer report on me from any Consumer Reporting Agency. Should the account be referred for collection, I (patient, agent, and guarantor) shall pay all reasonable costs of collection including but not limited to attorney's fees incurred as a result or as a result of any suit or claim that may be filed in connection therewith.

11. I have been informed of my patient rights and responsibilities. **PR given_____ (initials)**

    (By initialing above, I acknowledge that I have received a copy of Morris Hospital and Healthcare Centers Notice of Privacy Practices.)

12. I do acknowledge and certify that I have read the general conditions of admission or office setting care and that I am the patient or I am duly authorized to execute this acknowledgement on behalf of the patient. I accept the terms thereof of this agreement.

_____

Patient, Parent, or Guardian signature & Date

_____ _____

Relationship of above to patient **Witness of Signature & Date/ Time**

HEALTHCARE CENTERS OF
MORRI S HOSPI TAL

This Healthcare Center is a lab drawing station for Morris Hospital and all labs will be processed by the Morris Hospital laboratory. I am aware that my insurance may prefer or require an outside lab to be used for this processing and that I am responsible for the charges that my insurance does not pay.

_____ _____

Patient/Guardian signature Date

_____ _____

Witness Date Time

MORRIS HOSPITAL
& HEALTHCARE CENTERS

No Show Policy

Effective April 17, 2013

I understand that it is the policy of the Healthcare Centers of Morris Hospital to be given at least 24 hours notice when canceling an appointment. I understand that more than 3 failures to cancel appointments without proper notice may result in being discharged from the practice.

_____

Please Print Patient Name

_____

Patient or Parent/Guardian Signature Date

Illinois Department of Public Health

I-CARE Illinois Cares!

Illinois Comprehensive Automated Immunization Registry Exchange

Information On the I-CARE Registry

What is I-CARE?

The Illinois Comprehensive Automated Immunization Registry Exchange (I-CARE) is an immunization registry developed and managed by the Illinois Department of Public Health. Immunization registries are utilized by every state and provide a confidential computerized system to store necessary immunization records and provide immediate access to a patient's immunization status.

- Only authorized health care providers are allowed to search and update the immunization records of Illinois residents in I-CARE.

- The I-CARE registry has the ability to update immunization information, relieve parents of the burden of manually tracking their child's immunization records, print school physical forms, remind parents/patients when their immunizations are due and print a complete immunization record for patients to keep.

Why is I-CARE important for patients?

I-CARE makes managing your health records/information easier for you and your doctor. I-CARE:

- Keeps your immunization information continually updated
- Preserves immunization records if you change health care providers, move and lose paper records, or lose vital records in the event of an unexpected natural disaster
- Provides a copy of your immunization record when needed
- Sends reminders to let you know when you are due for an immunization
- Prevents your child from getting unnecessary or extra immunizations

How secure and private is the information in the I-CARE registry?

All information in I-CARE is confidential.

- The registry only collects information necessary information to identify a patient and track his/her immunization history.
- Access to the information in the registry is limited to authorized health care providers.

What is this "Opt Out of Registry Form"?

If an individual, parent or legal guardian does not want their immunization information saved in the I-CARE registry, they may fill out the following "Opt Out of Registry Form". Opting out of the registry will *require* patients to maintain and safeguard their own immunization records. Choosing to opt out of the registry will make it more challenging for your health care provider to remind you of upcoming and overdue immunizations.

I-CARE stores the information on the immunizations received, and calculates the immunizations needed to stay healthy and remain protected from vaccine-preventable diseases.

MORRIS HOSPITAL & HEALTHCARE CENTERS
People You Know. Extraordinary Care.

Tips for Your doctor Appointment

Your doctor is your partner in wellness.
Be prepared ahead of time to make the most out of you visit!
Here are a few simple tips for getting ready for a doctor's appointment.

Before Your Doctor Visit

Make a list of all the **prescription** and **over-the-counter** medicines you're taking. Bring this list to your appointments. Bring your medicines in their bottles, too.

Make a list of **questions** you have for your doctor about any old or new health problems.

Bring a copy of any **records** of medical visits or tests you have had with other doctors or health providers since your last visit with your regular doctor. You might also bring notes about family health history.

Read over material about your **health plan** so you understand how much you can expect to pay for your doctor visit and any tests or procedures.

During Your Doctor Visit

Time goes by fast during a doctor visit. Being prepared – having your medicine list and your list of questions – will help you get your concerns answered and make the most of the limited time you have with your doctor.

See the other side for questions you may want to ask!

After Your Doctor Visit

- ✓ Fill any prescriptions your doctor gave you
- ✓ Read any materials from the doctor or that came with any new medicines
- ✓ Organize your notes from the appointment
- ✓ Schedule any follow-up appointments
- ✓ Follow your doctor's instructions and recommendations
  - Did the doctor tell you to take medicine? **Take it!**
  - Did the doctor suggest lifestyle changes (eating better, exercising more)? **Do them!**

What kind of questions should you ask?

When talking with your doctor about a new health problem, make sure to ask…

- What is my diagnosis?
- What are my treatment options and how much do they cost?
- What side effects do I need to watch out for?
- What happens if I choose to not have treatment?
- What is the outlook for my future (prognosis)?

Whenever you get a new medication, make sure to ask…

- What is the name of the medicine?
- What is the medicine for?
- Can I take a generic drug?
- When should I take it?
- How much should I take?
- How long do I need to take the medicine?
- What side effects do I need to watch out for?
- Do I need to avoid any food, drinks, or activities?
- What should I do if I forget to take my medicine?
- What should I do if I accidentally take more than the recommended dose?
- Should I stop taking any of my other medicines or vitamins?

Whenever your doctor orders a test for you, ask…

- What is the test for?
- How is the test done?
- Is this test the only way to find out that information?
- How much will it cost me?
- What do I need to do to prepare for the test?
- When will I get the results?
- What's the next step after the test?

If you are having surgery, you might ask…

- Why do I need surgery?
- Is there some other way to treat my condition?
- What kind of surgery do I need?
- Have you done this surgery before?
- Which hospital is best for this surgery?
- How long will it take me to recover?
- How long will I be in the hospital?
- What will happen after the surgery?
- What will happen if I wait or don't have this surgery?

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes the limited ways in which Morris Hospital may use and disclose protected health information about you. It also describes your rights and our obligations with respect to such information. We are required by law and committed as an institution to maintain the privacy of protected health information and to provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. We are also required by law to comply with the terms and privacy practices stated in our notice that is currently in effect and we pledge to you that we will do so.

This notice applies to all use and disclosure of protected health information about you that is made by health care professionals, staff, employees, students, trainees, volunteers and certain associates of Morris Hospital at each facility in the Morris Hospital system. It also applies to any sharing of information among Morris Hospital facilities and locations. Your personal doctor may have different policies regarding use and disclosure of protected health information about you. You should be sure to check with each of your personal doctors and obtain a copy of the notice of privacy practices applicable to their respective use and disclosure of protected health information.

HOW WE USE AND DISCLOSE INFORMATION ABOUT YOU

The different ways in which Morris Hospital may use and disclose protected health information about you are described below. Each different type of use or disclosure is explained below. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as applicable.

Treatment. We may use and disclose protected health information to provide you with treatment and health care services. For example, a Morris Hospital doctor may use the readings created from taking your blood pressure to determine which medications may or may not be appropriate for you. We may use the results of tests that are performed on you to diagnose your condition or an illness that you may have, or we may disclose protected health information about you to doctors, nurses, technicians, medical students and other health care professionals who are involved in providing you with care.

Payment. Protected health information about you may be used and disclosed for payment purposes, including to facilitate, process, and receive payment for health care treatment and services that you receive at Morris Hospital facilities. For example, we may send your health plan or insurance company a detailed bill describing your treatment so that we can be paid, or you can be reimbursed, for care provided and services rendered at a Morris Hospital facility. If applicable, federal or state law requires us to obtain a written authorization from you prior to disclosing your protected health information for payment purposes; we will ask you to sign an authorization.

Health Care Operations. We may use and disclose protected health information about you in various ways for our health care operations. These uses and disclosures help us to provide you and the communities we serve with better quality care in a more efficient manner. We may combine protected health information about you with that about other patients to help us evaluate our performance and to determine necessary medical services in the community served. For example, we may use protected health information about you to review, assess, compare and improve the skills of individual Morris Hospital staff members, the overall level of care provided at a particular Morris Hospital facility, or the different levels of success achieved by a particular treatment among various Morris Hospital facilities and the possible causes for such differences.

Fundraising. We may use and disclose protected health information about you to contact you in our efforts to raise funds for Morris Hospital and its operations, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving such communications. If you do not wish to be contacted for fundraising purposes, please call the [Morris Hospital Foundation Office at 815-942-2932, extension 1435]. You may also submit your request in writing to the Privacy Officer listed below.

Facility Directory. We may disclose certain limited information about you in the facility directory of Morris Hospital while you are a patient there. This information may include your name, location in the Morris Hospital facility, your general condition (for example, fair, stable, etc.) and your religious affiliation. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. If you would like to opt out of being in the facility directory, please contact your Morris Hospital caretaker or the Privacy Officer listed below.

Individuals Involved in Your Care or Payment for Your Care. We may use or disclose to a family member, other relative, close personal friend, or any other person you identify, protected health information relevant to that person's involvement in your care or payment related to your care. We may exercise our professional judgment to determine if a disclosure is in your best interest and disclose only information that is directly relevant to the person's involvement with your health care. If you would like to restrict disclosures made to a family member, other relatives, close personal friends or any other person you identify, please contact your Morris Hospital caretaker or the Privacy Officer listed below.

Disaster Relief Efforts. In certain cases as permitted by law, we may release information to an entity assisting in a disaster relief effort so that they may notify your family members of your location and general condition. If you do not want us to disclose your protected health information for this purpose, you must communicate this to your caregiver so that we do not disclose this information unless done so in order to properly respond to the emergency.

Research. Under certain circumstances, we may use and disclose protected health information about you for research purposes. Before they begin, all research projects that are conducted at Morris Hospital are carefully reviewed, both with regard to the purpose and scope of the project itself and with regard to their use and disclosure of protected health information. Except in very limited circumstances as permitted by

applicable law, we will ask for your specific written permission if protected health information that identifies you will be used or disclosed in connection with a research project.

As Required by Law. Morris Hospital will use and disclose protected health information about you when we are required to do so by federal, state or local law.

Serious Threats to Health or Safety. We may use and disclose protected health information about you when necessary to prevent a serious threat to your health or safety, or the health and safety of other individuals or the public in general. For example, as further described below, we may be required to report cases of certain contagious or infectious diseases to public health authorities, or to report possible cases of child abuse or neglect to the proper authorities.

Health Oversight Activities. We may use and disclose protected health information about you to health oversight agencies for certain activities authorized by law for the appropriate oversight of the health care system, governmental benefit programs and regulatory or statutory compliance. For example, we may disclose information to facilitate and enable certain audits, investigations, inspections, licensing determinations and disciplinary actions.

Public Health. We may disclose protected health information for various public health activities and programs, authorized by law, of a number of different public entities or organizations, generally including the following:

- To prevent or control disease, injury or disability;
- To report vital statistics, such as births and deaths;
- To report child abuse and neglect to the appropriate authorities;
- To notify the appropriate authorities, if required by law to do so, of suspected cases of abuse, neglect or domestic violence;
- To report adverse reactions or events related to food or dietary supplements, product defects or problems, or biological product deviations;
- To notify persons of recalls of products that they may be using; and
- To notify persons who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Law Enforcement. We may disclose protected health information about you to law enforcement officials as permitted by law. Some of the circumstances in which we may do so include:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness or missing person; and
- To report criminal conduct on the premises of a Morris Hospital facility.

Workers Compensation. We may release protected health information about you to comply with workers' compensation laws or other similar programs that provide benefits for work-related injuries or illness.

Organ and Tissue Donations. We may use or disclose protected health information about you to facilitate organ, eye or tissue donation and transplantation, to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ, eye or tissue donation bank.

Legal Proceedings. We may share protected health information about you in response to a court or administrative order, discovery request, subpoena, or other lawful process, as authorized by applicable law.

Coroners, Medical Examiners, and Funeral Directors. We may disclose protected health information to coroners, medical examiners, and funeral directors as necessary for them to carry out their duties.

Military, National Security and Protective Services. Under certain conditions, we may disclose your protected health information for special government functions such as certain military, national security, and presidential protective services.

YOUR RIGHTS CONCERNING HEALTH INFORMATION ABOUT YOU

You have certain rights regarding the protected health information that we maintain about you. These rights include the following:

Restrictions. You have the right to request that we restrict or limit our uses and disclosures of protected health information about you. We are not required to agree to any request for a restriction of our uses and disclosures of protected health information about you, except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations and the information pertains solely to a health care item or service for which the health care provider has been paid out of pocket in full. To request a restriction on use and disclosure of protected health information about you, you must submit your request in writing to the Privacy Officer listed below.

Confidential Communications. You have the right to request that we communicate protected health information about you to you in some alternative means or at an alternative location. For example, you might request that we send letters to an address other than your home, or that we email information about you to an email address that you provide. To make such a request, you must submit your request in writing to the Privacy Officer listed below. Your request must specify the alternative means or location for communication with you. It also must state whether the disclosure of all or part of the protected health information in a manner inconsistent with your instructions would put you in danger. We will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your protected health information could endanger you.

Access. With certain exceptions, you have a right of access to inspect and obtain a copy of protected health information that we maintain about you. To inspect and obtain a copy of the protected health information that we maintain and may use to make decisions about you and your care, please submit your request in writing to the Privacy Officer listed below. If you request a copy of your protected health information, we may charge you a reasonable fee to cover our costs.

Amendment. You have a right to request an amendment to your protected health information that we have about you if you believe that information is incorrect or incomplete. To request an amendment of the protected health information that we maintain and may use to make decisions about you and your care, please submit your request in writing to the Privacy Officer listed below, along with a description of the reason for your request. We may deny your request for amendment. In case of any such denial, we will provide you with a written explanation of why we denied the request and of your rights.

Accounting of Disclosures. You have the right to receive an accounting of certain disclosures we have made of your protected health information. You may submit your request in writing to the Privacy Officer listed below. You must include the time period in the past that the accounting is to cover. This time period may not be longer than six years prior to the date of your request. You should also indicate the form in which you wish to receive the accounting (for example, on paper or on electronic media). There will be no charge to you for the first accounting that we provide to you in any 12 month period. We may charge you a fee to cover our costs for producing additional accountings of disclosures that you request in a 12 month period.

Notification of a Breach. You will receive notification of breaches of your unsecured protected health information as required by law.

Paper Copy of Notice. You have the right to receive a paper copy of this notice, even if you have agreed to receive this notice electronically. You may request a paper copy of our notice at any time simply by asking for one at any Morris Hospital facility, by contacting our Privacy Officer listed below.

OTHER USES AND DISCLOSURES OF INFORMATION ABOUT YOU

Other than as described above in this notice, we will only use and disclose protected health information about you with your prior written authorization, including uses and disclosures for certain marketing activities, sale of protected health information, and disclosure of psychotherapy notes with some exceptions. You may revoke any such authorization, in writing, at any time. After your revocation, we will not further use or disclose protected health information about you for the purposes covered by the revoked authorization. However, such a revocation will not be effective for uses or disclosures that have already been made or other actions that have already been taken, in reliance on the authorization or for those that are required by law. You may make a written revocation of your prior authorization by contacting our Privacy Officer listed below.

CHANGES TO THIS NOTICE

We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all health information we maintain. If we amend this notice, we will provide the revised version on our website (www.morrishospital.org) and we will provide you with a copy of the notice that is currently in effect, upon your request.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with us by sending a brief written description to the Privacy Officer listed below. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, or by visiting http://www.hhs.gov/ocr/privacy/hipaa/complaints. At Morris Hospital, we constantly strive to improve our service and are eager to listen to feedback from our patients. Please be assured that you will not be penalized or retaliated against in any way for filing a complaint.

CONTACT

We would be happy to discuss our privacy practices further with you and ease any possible concerns that you might have. If you have any questions about this notice or any of our privacy practices, please contact us at:

Morris Hospital
150 W. High St.
Morris, Illinois 60450
Attn: Privacy Officer

Telephone: (815) 942-2932
Fax: (815) 942-3154

This Notice of Privacy Practices becomes effective on 9/23/2013, and replaces all earlier versions.

CH01/ 26240117.1

ADDENDUM TO NOTICE OF PRIVACY PRACTICES

This Addendum supplements the Notice of Privacy Practices, which is attached hereto. The provisions below describe in additional detail the ways in which Morris Hospital may use and disclose protected health information about you, and further describes your rights and our obligations with respect to protected health information:

HOW WE USE AND DISCLOSE INFORMATION ABOUT YOU:

Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as applicable.

Fundraising. We may use and disclose protected health information about you for fundraising purposes as permitted by applicable law. If you do not wish to receive information relating to our fundraising efforts, you may opt out of receiving such communications.

YOUR RIGHTS CONCERNING HEALTH INFORMATION ABOUT YOU:

Restrictions. We are not required to agree to your request for a restriction of our uses and disclosures of your health information, except where the disclosure is to a health plan for purposes of carrying out payment or health care operations and the information subject to such disclosure pertains solely to a health care item or service for which the health care provider has been paid out of pocket in full.

Notification of Breach. You will receive notification of breaches of your unsecured protected health information as required by law.

OTHER USES AND DISCLOSURES OF INFORMATION ABOUT YOU:

Other than as described in the Notice of Privacy Practices and this Addendum, we will only use and disclose protected health information about you with your prior written authorization, including uses and disclosures for certain marketing activities, sale of protected health information, and disclosure of psychotherapy notes with some exceptions.

[Effective Date: September 23, 2013]

STATEMENT ON PATIENT'S RIGHTS AND RESPONSIBILITIES

The Morris Hospital & Healthcare Centers presents a statement on the patient's rights and responsibilities with the expectation patients have a fundamental right to considerate and respectful care that safeguards their personal dignity and respects their cultural, psychosocial, and spiritual values. Understanding and respecting these values guide the provider in meeting the patients' care needs and preferences and will contribute to more effective patient care and greater satisfaction for the patient, his physician, and the Hospital organization. It is recognized that the basic rights of human beings for independence of expression, decision and action take on a new dimension during sickness, and especially in an organizational structure. It is in recognition of these concerns that Morris Hospital & Healthcare Centers affirms its responsibility to endeavor to assure that these rights are preserved for patients. Morris Hospital & Healthcare Centers respects a patient's right to delegate his/her right to make informed decisions to another person (as allowed under State Law).

Patient's Rights:

A. The patient or his/her representative has the right to participate in the development and implementation of his or her plan of care.

B. The patient or his /her representative has the right to make informed decisions regarding his or her care. The patient's rights include being informed of their health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right is not a mechanism to demand treatment or services deemed medically unnecessary or inappropriate.

C. The right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives.

D. The right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital.

E. The right to personal privacy.

F. The right to receive care in a safe setting.

G. The right to be free from all forms of abuse or harassment.

H. The right to the confidentiality of his or her clinical records.

I. The right to access information contained in his or her clinical records within a reasonable time frame.

J. The right to be free from restrains of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff.

K. The right to be fully informed of and consent or refuse to participate in any unusual, experimental or research project without compromising his/her access to services.

L. The right to know the professional status of any person providing his/her care/services.

M. The right to know the reason for any proposed change in the professional staff responsible for his/her care.

N. The right to know the reasons for his/her transfer either within or outside the hospital.

O. The right to know the relationship(s) of the hospital to other persons or organizations participating in the provision of his/her care.

P. The right of access to the cost, itemized when possible, of services rendered within a reasonable period of time.

Q. The right to be informed of the source of the hospital's reimbursement for his/her services, and of any limitation which may be placed upon his/her care.

R. To be informed of the right to have pain treated as effectively as possible.

S. To be informed of the policies and procedures of the hospital regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reason for the clinical restriction or limitation. To inform the patient (or support person, where appropriate, of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same sex domestic partner, and other family member, or a friend, and his or her right to withdraw or deny such consent at any time. Not restrict, limit or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. To ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences.

T. The patient's family has the right of informed consent for donation of organs and tissues.

STATEMENT ON PATIENT'S RIGHTS AND RESPONSIBILITIES

Patient Responsibilities:

A. The safety of healthcare is enhanced by the involvement of the patient as a partner in the healthcare process. A patient has the responsibility to provide, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his health. He/She has the responsibility for reporting perceived risks in their care and unexpected changes in his condition to the responsible practitioner. A patient is responsible for making it known whether he/she clearly comprehends a contemplated course of action and what is expected of him/her. The patient and family help the hospital improve its understanding of the patient's environment by providing feedback about service needs, expectations and safety issues.

B. A patient is responsible for following the care, service or treatment plan recommended by the practitioner primarily responsible for his/her care. This may include following the instructions of Nurses and allied health personnel as they carry out the coordinated plan of care and implement the responsible practitioner's orders, and as they enforce the applicable Hospital rules and regulations. The patient is responsible for asking questions when they do not understand what they have been told about their care or what they are expected to do. The patient should express any concerns they have about their ability to follow and comply with the proposed care plan or course of treatment. The patient is responsible for keeping appointments and when he/she is unable to do so for any reason, for notifying the responsible practitioner or the Hospital.

C. The patient is responsible for outcomes if they do not follow the care, service or treatment plan.

D. The patient is responsible for assuring that the financial obligations of his/her healthcare are fulfilled as promptly as possible.

E. The patient is responsible for following Hospital rules and regulations concerning patient care and conduct.

F. The patient is responsible for being considerate of the rights and safety of other patients and Hospital personnel, and helping control of noise and disturbances, following smoking policies and limiting the number of visitors. The patient is responsible for being respectful of the property of other persons and of the Hospital.

G. The patient or his/her surrogate is responsible for notifying healthcare providers of the patient's Durable Power of Attorney for Healthcare or Living Will and its amendment or revocation. This document must be presented.

Rights and Responsibilities of Neonatal, Pediatric and Adolescent Patients:

A. The parents or legal guardians of neonatal, pediatric and adolescent patients shall assume the aforementioned rights and responsibilities on their behalf.

Patients will be made aware of their right to voice concerns and complaints in the following manner via the Patient Rights and Responsibilities handout, including:

A. The hospital takes quality of care very seriously and encourage patients or patient representatives to contact hospital management with any concerns as soon as they arise. Please feel free to contact the manager of the department, or the Risk Manager at 815-705-7701 if you have any concerns about safety or quality of care issues. The house supervisor can assist you during the evening and midnight shifts.

B. If concerns cannot be resolved through the hospital, patients and family may contact the Illinois Department of Public Health, Central Complaint Registry, at 800-252-4343, (for hearing impaired use TTY 800-547-0466) or write to the Illinois Department of Public Health, Division of Healthcare Facilities, 525 W. Jefferson St., Springfield, IL 62761-0001 or fax: 217-782-0382.

Interpretive Services

Morris Hospital & Healthcare Centers provides language interpretation 24 hours a day at no cost to the patient.
These services are available upon request or as identified by a healthcare provider.