Registration Form

The Project of the Quad Cities recognizes all genders and identities; however, many insurance companies and legal entities unfortunately do not. Please be aware that the legal name and sex you have listed with your insurance must be used on all documents. When addressing you, we will always use the name and pronouns that you request to assure that we are using the most respectful language.

CLIENT INFORMATION		
Name You Go By: Kim	**Name On Legal Documents:**	
Date of Birth:	**Social Security Number:**	**Pronouns:**
Address:	**City/State/Zip:**	
Client Phone:	**Other Phone:** **Name:**	**Other Phone:** **Name:**
May we contact you by: ☐ Mail ☐Phone ☐Text ☐Email **Email address:**		****Preferred contact method:** ☐Mail ☐Phone ☐Text ☐Email ☐ No contact
Primary Language:		**Interpreter Needed:** Yes ☐ No ☐ Language:___
Sex Assigned at Birth: ☐ Male ☐ Female ☐ Intersex	**Legal Sex:** ☐ Male ☐ Female ☐ X	
Gender Identity: ☐Female ☐Male ☐Cisgender ☐Two-Spirit ☐Transgender Male ☐Transgender Female ☐ Nonbinary ☐Genderqueer/Gender Non-Conforming ☐Questioning ☐Decline ☐_____		
Sexual Orientation: ☐Gay ☐Lesbian ☐Bisexual ☐Queer ☐Asexual ☐Pansexual ☐Straight/Heterosexual ☐ Questioning ☐ Decline ☐: _____		
Relationship Status: ☐Single ☐Cohabitating ☐Married ☐Separated ☐Divorced ☐Widowed ☐In A Relationship		
Race: ☐Black/African American ☐White ☐Alaskan Native ☐Native American ☐Pacific Islander ☐Native Hawaiian ☐ Asian Indian ☐Asian Other ☐Chinese ☐Filipino ☐Guamanian or Chamorro ☐Japanese ☐Korean ☐Samoan ☐Vietnamese ☐Multiracial ☐Decline ☐Do not know ☐_____		
Ethnicity: ☐Hispanic or Latino/a/x ☐Non-Hispanic ☐Another Hispanic, Latino/a/x or Spanish Origin ☐Cuban ☐Mexican, Mexican American, Chicano/a ☐Puerto Rican ☐Decline ☐_____		**Birth Country:**

HEAD OF HOUSEHOLD INFORMATION (for clients under the age of 18)		
First and Last Name:	**Relationship:**	**Date of Birth:**
Phone Number:	**Address:**	
May we contact you by: ☐ Mail ☐Phone ☐Text ☐Email **Email address:**		****Preferred contact method:** ☐Mail ☐Phone ☐Text ☐Email ☐ No contact
Sex Assigned at Birth: ☐ Male ☐ Female ☐ Intersex	**Legal Sex:** ☐ Male ☐ Female ☐ X	
Gender Identity: ☐ Female ☐ Male ☐ Cisgender ☐ Two-Spirit ☐ Transgender Male ☐ Transgender Female ☐ Nonbinary ☐ Genderqueer/Gender Non-Conforming ☐ Questioning ☐ Decline ☐ Other:_____		

Registration Form

INSURANCE INFORMATION		
Primary Insurance Company Name:	ID #:	Group #:
Insurance Company address/city/state/zip		
Policy Holder Name:	Policy Holder DOB:	Insurance Start Date:
Secondary Insurance Company Name:	ID #:	Group #:
Insurance Company address/city/state/zip		
Policy Holder Name:	Policy Holder DOB:	Insurance Start Date:
☐ Decline to use insurance (please provide reason): ****We will attempt to verify insurance coverage and bill your insurance provider unless you "decline to use insurance".****		

EMERGENCY CONTACT INFORMATION		
First and Last Name:	**Relationship:**	**ROI Complete:** ☐ Yes ☐ No
Phone Number:	**Address:**	

I have completed this self-report and agree the information I have provided is accurate.

I give my permission to the release of health/financial information that is needed to conduct audits and/or process insurance claims including: HIV, mental health, STDs, genetic testing, and substance use.

I understand that TPQC (The Project of the Quad Cities) will attempt to verify insurance coverage and bill my insurance provider unless I mark the "decline to use insurance" box above.

Client Printed Name _____ Client Signature (Minor's signature if 12 through 17) _____ Date _____

Parent/Guardian/Representative Signature (If applicable) _____ Relationship to client _____ Date _____

How did you hear about The Project of the Quad Cities?

☐ Facebook ☐ A current client ☐ Clinic/testing ☐ Friend/Partner/Family ☐ Outreach event ☐ Other: _____

MRN:

Registration Receipt of Documents

Legal Name of Client: _____

Preferred Name of Client: _____

Date of Birth: _____/ _____/ _____

HIPAA Privacy Practices Acknowledgment

Notice of Privacy: The Project of the Quad Cities (TPQC) Notice of Privacy Practices was given to you when you registered. By initialing below, you acknowledge that you have received the Notice of Privacy Practices.

Initial Here_____

Client Rights and Responsibilities Acknowledgment

Rights and Responsibilities: Copy of TPQC's Client Rights and Responsibilities was given to you when you registered. You have read the Rights and Responsibilities and had any questions about them answered. By initialing below, you acknowledge that you received a copy of the Rights and Responsibilities, and you understand them.

Initial Here_____

Complaint Process Acknowledgment

Grievance Policy: TPQC's Complaint Process was given to you when you registered. By initialing below, you acknowledge that you received the Complaint Process.

Initial Here_____

Consent for Treatment Acknowledgment

Consent for Treatment: TPQC's Consent for Treatment was given to you when you registered. You have read the Consent for Treatment and had any questions about it answered. By initialing below, you acknowledge that you received the Consent for Treatment, and you understand it.

Initial Here_____

Client Signature_____ Date _____

Guardian Signature_____ Date _____

(If different from the client listed)

Employee Witness to Signature_____ Date _____

Notice of Privacy Practices

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

The Project of the Quad Cities (TPQC) is required by law to maintain the privacy of patients' Protected Health Information (PHI) and to provide individuals with the following Notice of the legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice. We reserve the right to change the terms of this Notice and these new terms will affect all PHI that we maintain at that time.

In certain circumstances we may use and disclose PHI about you without your written consent:

For Treatment: We will use health information about you to provide you with medical treatment or services. We will disclose PHI about you to doctors, nurses, technicians, students in health care training programs, or other personnel who are involved in taking care of you.

For Payment: We will use and disclose information to other health care providers to assist in the payment of your bills. We will use it to send bills to your insurance company, or other payers, such as Medicare, for the care, treatment, and other related services you receive. We may tell your health insurer about a treatment your doctor has recommended to obtain prior approval to determine whether your plan will cover the cost of the treatment.

For Health Care Operations: We may use and disclose PHI about you for the purpose of our business operations. These business uses and disclosures are necessary to make sure that our patients receive quality care and cost-effective services. For example, we may use PHI to review the quality of our treatment and services, and to evaluate the performance of our staff, contracted employees, and students in caring for you.

Business Associates: We may use or disclose your PHI to an outside company that assists us in operating our health system. They perform various services for us. This includes, but is not limited to, auditing, accreditation, legal services, and consulting services. These outside companies are called "business associates" and they contract with us to keep any PHI received from us confidential in the same way we do. These companies may create or receive PHI on our behalf.

Family Members and Friends: If you agree, do not object, or we reasonably infer that there is no objection, we may disclose PHI about you to a family member, relative, or another person identified by you who is involved in your health care or payment for your health care. If you are not present or are incapacitated or it is an emergency or disaster relief situation, we will use our professional judgment to determine whether disclosing limited PHI is in your best interest under the circumstances.

Appointments: We may use and disclose PHI to contact you for appointment reminders and to communicate necessary information about your appointment.

Contacting you: We may contact you about treatment alternatives or other health benefits or services that might be of interest to you.

Marketing: Uses and disclosures for marketing will only be made with an authorization from you.

Sale of PHI: TPQC cannot sell your protected health information (PHI) without your permission and will not be released without an authorization from you.

Psychotherapy Notes: Uses and disclosures for psychotherapy notes will only be made with an authorization from you.

Required or Permitted by Law: We may use or disclose your PHI when required or permitted to do so by federal, state, or local law.

Public Health Activities: We may use or disclose your PHI for public health activities that are permitted or required by law. For example, we may disclose your PHI in certain circumstances to control or prevent a communicable disease, injury or disability; to report births and deaths; and for public health oversight activities or interventions. We may disclose your PHI to the Food and Drug Administration (FDA) to report adverse events or product defects, to track products, to enable product recalls, or to conduct post-market surveillance as required by law or to a state or federal government agency to facilitate their functions. We also may disclose protected health information, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

Health Oversight Activities: We may disclose your PHI to a health oversight agency for activities authorized by law. For example, these oversight activities may include audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and government agencies that ensure compliance with civil rights laws.

Lawsuits and Other Legal Proceedings: We may disclose your PHI in the course of any judicial or administrative proceeding or in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized). If certain conditions are met, we may also disclose your protected health information in response to a subpoena, a discovery request, or other lawful process.

Abuse or Neglect: We may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, if we believe you have been a victim of abuse, neglect, or domestic violence, we may disclose your protected health information to a governmental entity authorized to receive such information.

Law Enforcement: Under certain conditions, we also may disclose your PHI to law enforcement officials for law enforcement purposes. These law enforcement purposes include, by way of example, (1) responding to a court order or similar process; (2) as necessary to locate or identify a suspect, fugitive, material witness, or missing person; (3) reporting suspicious wounds, burns or other physical injuries; or (4) as relating to the victim of a crime.

To Prevent a Serious Threat to Health or Safety: Consistent with applicable laws, we may disclose your PHI if disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Coroners, Medical Examiners and Funeral Directors: We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We may also release your PHI to a funeral director, as necessary, to carry out his/her duties.

Other Uses and Disclosures of PHI

Most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes and disclosures that constitute the sale of PHI require your written authorization.

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. If you provide TPQC with an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that we have used or disclosed in reliance on the authorization.

Your Rights Regarding Your PHI:

The Right to Access to Your Own Health Information: You have the right to inspect and copy most of your protected health information for as long as we maintain it as required by law. All requests for access may be made via telephone, writing or in person. You also have the right to ask for a summary of this information.

Right to Request Restrictions: You have the right to request certain restrictions of our use or disclosure of your PHI. We are not required to agree to your request. But if TPQC agrees to the restriction, we will comply with your request unless the information is needed to provide you emergency treatment. TPQC will agree to restrict disclosure of PHI about you to a health plan if the purpose of the disclosure is to carry out payment or health care operations and the PHI pertains solely to a service for which you, or a person other than the health plan. The patient has the right to restrict disclosures of PHI to health plans if the individual has paid for services out-of-pocket, in full, and the individual requests that TPQC not disclose any PHI related solely to those services. A request for restriction should be made in writing. We reserve the right to terminate any previously agreed-to restrictions (other than a restriction we are required to agree to by law). We will inform you of the termination of the agreed-to restriction and such termination will only be effective with respect to PHI created after we inform you of the termination.

Right to Request Confidential Communications: If you believe that a disclosure of all or part of your PHI may endanger you, you may request in writing that we communicate with you in an alternative manner or at an alternative location. For example, you may ask that all communications be sent to your work address. Your request must specify the alternative means or location for communication with you. It also must state that the disclosure of all or part of the PHI 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.

Right to be Notified of a Breach: You have the right to be notified in the event that we (or one of our Business Associates) discovers a breach of unsecured protected health information involving your medical information.

Right to Inspect and Copy: You have the right to inspect and receive a copy of PHI about you that may be used to make decisions about your health. A request to inspect your records may be made.

Complaints: You may submit any complaints with respect to violations of your privacy rights to the Clinic Manager. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services if you feel that your rights have been violated. There will be no retaliation from TPQC for making a complaint.

For more information, or to file a complaint, please contact the Clinic Manager at 309-762-5433.

Consent for Treatment

I agree to receive routine treatments and procedures that my medical and/or behavioral health provider believe will help improve my health. A "routine" treatment or procedure is one that is regularly offered in an outpatient center like The Project of the Quad Cities (TPQC). I understand that my medical and/or behavioral health provider will work with me to diagnose and treat my health issues. Therefore, I agree to receive medicine and/or treatment that my medical and/or behavioral health provider believes will help to diagnose and/or treat problems I am having or improve my health and wellness.

Routine medical treatments and procedures at TPQC may include:

- Asking questions about my medical history and my health
- A physical exam
- Measuring my blood pressure, temperature, height, and weight
- Prescribing and/or giving me medicine
- Having blood drawn for tests
- Screening for infectious diseases such as HIV, HCV, Syphilis, Chlamydia, or Gonorrhea

Routine therapy treatments and procedures may include:

- Asking questions about my mental health history and how I am feeling.
- Discussing my concerns and problems
- Creating a plan for therapy together

If my provider recommends any "non-routine" treatments, procedures, or medicines, we will talk about that separately. I may get a special consent form for care that is non-routine that will be explained and reviewed with me by my medical or behavioral health provider.

I understand that:

- TPQC cannot promise that I will get good results from the treatment,procedures, services, and medicine I receive.

- My medical and/or behavioral health provider will explain the benefits and possible risks from the routine treatment, procedures, services, and medication Imay receive and will tell me about other options too.

- I will have a chance to ask questions and get answers I understand about any concerns I have.

- I will be able to choose the treatments, procedures, services, and medicines that are suggested to me. I can choose to take some and refuse some of the treatments, procedures, services, and medicines that are suggested to me.

- I can change my mind about the services I want at any time, but TPQC cannot reverse care I have already gotten.

- If I refuse to consent to all treatment, I cannot be treated at TPQC. Instead, TPQC will give me referrals to other providers or health care agencies.

I understand that my providers at TPQC work together to provide integrated health care and to provide me the best health care experience. To do that, information about me may be shared with other necessary TPQC staff involved in my care, such as my nurse, my medical provider, my case manager, and my behavioral health provider.

I understand that information I give TPQC is confidential and cannot be shared with anyone outside of TPQC without my written permission except as required by law. I understand that if eligible for and participating in HIV or HCV screening under an IDPH testing grant, my health information will be reported to Illinois Department of Public Health via Provide Enterprise Software. I understand that TPQC is required to report information to the State of Illinois Immunization Registry. I understand that TPQC may have to share some information with outside organizations about me without my permission when any of the following things happen:

- If TPQC finds out about or suspects child abuse, elder abuse or abuse of someone that is disabled, it is required to report information to protect the person that may be abused.

- If TPQC believes that I am at a high risk of hurting or killing myself or someone else, TPQC must help keep me and the other person safe.

For more information about how my information can, cannot or must be shared, I can review the TPQC Privacy Policies and the TPQC Patient Rights and Responsibilities.

Statement of Client Rights

You have the right:

- To access services which will not be denied based on economic status, disability, national origin, ethnicity, race, religion, gender, gender presentation or gender identity, sexual orientation, or HIV status (in accordance with the Americans with Disabilities Act).
- To be treated as an important member of your healthcare team and to have your choices and needs valued.
- To receive care in a safe and secure environment, free from physical, verbal, or sexual harassment, swearing or disorderly conduct.
- To have all information about you, including HIV status, treated in a confidential manner in accordance with Federal and State laws.
- To receive information about your diagnosis, medical condition, and treatment in language you understand.
- To request a copy of your medical records.
- To be informed of services and programs available to you at The Project of the Quad Cities (TPQC)
- To receive services from other organizations with or without the assistance of TPQC staff.
- To refuse service or end your participation in any or all services provided by TPQC and to have the consequences of this decision explained to you without punishment or penalty.
- To know where and how to register a complaint or concern, and to know that your complaint or concern will be taken seriously.
- To know that you will not be penalized for registering a complaint or concern.
- To ask for the services of an interpreter and to know that TPQC will provide one.
- To continue to receive services if your financial circumstances or insured status has changed.

Statement of Client Responsibilities

You have the responsibility:

- To be an active member of your health care team and to follow the treatment plan that you and your provider agree upon.
- To ask questions and tell us when you do not understand a treatment option or decision being considered.
- To help your provider understand your concerns and the way your life circumstances may impact your care.
- To keep your provider informed of all services you are receiving from outside agencies or individuals.
- To notify The Project of the Quad Cities (TPQC) immediately if your contact or personal information and/or if your insured status or financial circumstances change.
- To come to your appointment without being under the influence of alcohol or illicit drugs. If you are under the influence of alcohol or other illicit substances, you may not be seen and you may be asked to reschedule your appointment.
- To attend your appointment and to arrive 10-15 minutes before your scheduled appointment time.
    - Please provide at least 24 hours advanced notice if you need to cancel your appointment.
- To answer all questions and fill out all paperwork completely and honestly, including (but not limitedto) information about your financial status, health conditions and care received elsewhere.
- To treat everyone at TPQC with respect. Physical, verbal, or sexual harassment of staff or other clients, swearing or disorderly conduct will not be tolerated. This type of behavior may result inimmediate termination from TPQC services.
- To not talk about or share anything you learn about other people who receive care at TPQC.
- To share your compliments and concerns and provide suggestions that will help us provide you thebest care possible

Description of Services and Clinical Complaint Process

The Project of the Quad Cities (TPQC) promotes the health and well-being of LGBTQ+ people and marginalized communities to enhance their lives through health care and wellness programs. TPQC offers primary medical care, STD clinic, counseling, and case management services. Our services are designed to serve LGBTQ+ people; marginalized communities, people impacted by HIV/AIDS and allies in a confidential, supportive environment.

Description of Services

Medical Care: Anyone is eligible to receive care based on availability regardless of ability to pay. Services include comprehensive primary care, HIV/STI testing and counseling.

Counseling: Anyone is eligible to receive care based on availability regardless of ability to pay. Services include individual, couples, family and group counseling, substance abuse counseling, and support groups.

Case Management: Anyone who is living with HIV is eligible to receive case management based on availability. Services include needs assessment, development of service plan, medical case management, treatment adherence, support with accessing benefits and entitlement programs, resource referral, emergency financial aid (based on need), transportation, and legal assistance.

Complaint Process

We appreciate client feedback and encourage you to offer us the opportunity to address any concerns you may have. If you feel that you have not been treated fairly, that your rights have been violated or that the quality of the services you received were poor, please consider taking one of the following steps:

- If you feel comfortable, please discuss your concern with the staff member offering your services.The staff member will attempt to resolve the complaint and will inform you about the available alternatives or actions they can take to resolve your concern.

- If you are not comfortable speaking directly with the staff member or if you are still dissatisfied after speaking with the staff member, you can speak with that staff member's supervisor. The staff member's supervisor will attempt to resolve the complaint and will inform you about the available alternatives or actions they can take to resolve your concern. If the staff member's supervisor is not immediately available, the supervisor will attempt to contact you as soon as possible, but no later than 2 business days.

- If you are unsatisfied with the supervisor's response and proposed solution, you can talk to the department director for a response and proposed resolution.

If at any time, you are uncomfortable speaking with anyone directly about your complaint, you fill out a Client/Patient Complaint and Grievance Form that includes a written description of

1. The circumstances surrounding the complaint.
2. Actions TPQC staff took to resolve the complaint to date and
3. The action you are requesting to resolve the complaint.

Client/Patient Complaint and Grievance Forms are available at the front desk and on the TPQC website. You may leave the Form at the front desk, mail the form to the Director of Quality at 1601 River Drive, Suite 310, Moline, IL 61265 or submit via email at hello@tpqc.org.

Clients/Patients, who have a complaint or grievance about TPQC services funded through the Ryan White Program, can contact the Director of Supportive Services at 309-762-5433.

Client/Patient Complaint and Grievance Form

The Project of the Quad Cities (TPQC) appreciates your feedback and is committed to ensuring a high-quality experience for all clients and patients. If you feel that you have been treated unfairly, that your rights have been violated, or that you received poor quality services, please fill out this form and give it to a staff member or mail it to TPQC Director of Quality, 1601 River Drive, Suite 310, Moline, IL 61265. You can also call 309-762-5433 and leave a message to talk to TPQC's Director of Quality.

Someone from The Project of the Quad Cities will contact you within two business days of receipt. We encourage you to raise your concern as soon as possible, at least within 30 days, so that we can address and resolve your concerns. Clients and patients will not be penalized in any way and will still be able to use the services at The Project of the Quad Cities after raising a complaint or concern.

Contact Information:

Name	Phone Number
Mailing Address	Email Address
You may contact me by (check all that apply): ☐ Phone ☐ US Mail ☐ Email	

Tell us about your concerns:

Day it happened:	Time it happened:
Please describe what happened, including staff involved and any suggestions you have to resolve your concern. *You can attach more paper or write on the back of this form if you need more space*	

INTERNAL USE:
Circle one: Complaint Grievance

Staff initials and date form received: _____ Date initial contact: _____
Date resolved: _____