Illinois Pathways to Health by AgeOptions

Registration Form

Workshop ID: _____

First Name*: _____ Last Name*: _____

Email Address: _____

Phone Number*: _____ Date of Birth*: _____

Address*: _____

City*: _____ State*: _____ Zip Code*: _____

Emergency Contact Name: _____ Phone Number: _____

HEALTH INSURANCE INFORMATION

Most Health Promotion programs offered through the Illinois Pathways to Health Initiative are available at no cost to the participant through grants and federal funding. We will NOT bill your insurance without your consent. Listing the information below helps us to know who we are reaching to secure funding for future programs.

From what health system do you receive your primary healthcare care services?

Advocate Aurora Health	☐	Mercy Health Corporation	☐
Amita Health	☐	NorthShore University Health System	☐
Blessing Health System	☐	Northwestern Memorial Health Care	☐
Carle Health	☐	OSF Health Care	☐
Cook County Health	☐	Presence Health	☐
Edward-Elmhurst Health	☐	Rush	☐
Hospital Sisters Health System	☐	Sinai Chicago	☐
Kindred Healthcare	☐	Southern Illinois Healthcare	☐
Loyola Medicine	☐	Swedish American Health System	☐
Memorial Health System	☐		

What type of health insurance do you have? Check all that apply.

☐ Medicare ☐ Private Insurer of Employer ☐ Decline to Provide

☐ Medicaid ☐ Uninsured/ Self-pay

	Insurance Plan Info *(Primary)*	**Insurance Plan Info *(Secondary)***
Insurance Plan Name:		
Group ID #:		
Member ID #:		

Acknowledgment of Receipt of Notice of Privacy Policy

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in the Illinois Pathways to Health by AgeOptions Notice of Privacy Practices. AgeOptions is permitted to revise their Notice of Privacy Practices at any time. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

By signing below, you are acknowledging that you have received a copy of the Notice of Privacy Practices.

Participant's Printed Name: _____

Patient Representative: _____

If signed by Patient Representative, state authority to act on behalf of patient:

_____

Participant/Representative Signature: _____ Date: _____

Entity Use Only

I, _____, attempted to obtain the participant's acknowledgement of receipt of the Notice of Privacy Practices, but was unable to do so.

Reason acknowledgment not obtained: _____

_____

Signature: _____ Date: _____

Illinois Pathways to Health by AgeOptions

Release and Waiver of Liability Agreement

Workshop ID: _____

As a participant in this class, the undersigned agrees to indemnify and release and hold harmless AgeOptions and organizations affiliated with Illinois Pathways to Health, their directors, officers, employees, and agents from any loss, liability, injury, cost, or damage they may incur resulting from such class participation.

In addition, by signing below, the undersigned agrees:

- Information provided in the class does not replace the advice of medical professionals;
- To address concerns with the undersigned's medical provider if the undersigned believes the information in the class conflicts with the advice of the undersigned's medical provider;
- The undersigned has been informed that the sessions may include light to moderate exercise, including stretching, balance, and range of motion exercises;
- The undersigned assumes full responsibility for and risk of bodily injury, death, or property damage due to negligence or releasees or otherwise while participating in any class affiliated with Illinois Pathways to Health by AgeOptions; and
- To work within their own comfort zone and agrees to stop participating if they feel any pain or discomfort and will let one of the class instructors know about their condition or concerns.

Program Name: _____

Site Name: _____

Participant's Printed Name: _____

Participant Signature: _____ Date: _____