LA GRANGE MEDICAL CENTER/6170 JOLIET ROAD/COUNTRYSIDE, IL/60525

PATIENT INFORMATION

LAST NAME ______________________________ FIRST NAME __________________ MI ____

STREET ____

CITY ___________________________________STATE_____________ ZIP CODE __________

PHONE _________________CELL PHONE __________________ E-MAIL: ___________________

S/S/ # ____________________ GENDER M F MARITAL STATUS: S M D W

DATE OF BIRTH: ______________

EMPLOYER ___________________________________ OCCUPATION ____________________

STREET ______________________________ CITY ____________________ STATE__________

ZIP CODE _____________________ WORK PHONE ___________________________________

EMERGENCY CONTACT NAME ________________ PHONE NUMBER ______________

RELATIONSHIP TO YOU _____________________________ CELL PHONE ________________

REASON FOR VISIT: ____

HOW DID YOU HEAR ABOUT US? Please circle one of the following: Referral___________________________

Yellow Pages Yelp ZocDoc Bing Yahoo Google Other ____________________. If you selected Google, Bing or Yahoo, what did you type in the search box? Ex. "Immediate Care Hodgkins"__________________________

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE ______________________________ PPO POS HMO OTHER

YOU MUST PROVIDE A COPY OF YOUR INSURANCE CARD(S) TO OUR BILLING DEPARTMENT

POLICY NUMBER ____________________________ GROUP NUMBER ___________________

NAME OF INSURED ______________________________ DATE OF BIRTH ________________

S/S# _____________________________________ RELATIONSHIP TO YOU ________________

NAME OF SECONDARYINSURANCE _______________________

PPOLICY NUMBER _____________________________ GROUP NUMBER __________________

NAME OF INSURED ______________________________ DATE OF BIRTH _________________

S/S# ____________________________________ RELATIONSHIP TO YOU __________________

LA GRANGE MEDICAL CENTER/6170 JOLIET ROAD/COUNTRYSIDE; IL/60525

PATIENT INFORMATION

PLEASE DESCRIBE YOUR PROBLEM OR INJURY:

IF ILLNESS:

Please describe the symptoms or concerns that brought you here today:

____

If Accident:____

Please describe what happened and where: ________________________________

____

DATE OF INJURY/ACCIDENT: ____________________________

____ Worker's Compensation ____ Auto Accident ____ Other Accident

If Worker's Compensation:
NAME OF PERSON WHO AUTHORIZED THREATMENT AT YOUR PLACE OF WORK:

________________________________ PHONE # __________________

IF AUTO, PLEASE COMPLETE OTHER PAPERWORK TO BE FURNISHED AT TIME OF VISIT.

IF ANY OTHER LIABILITY:

INSURANCE OR OTHER PARTIES RESPONSIBLE:

NAME: ____________________________ PHONE:______________________

NAME: ____________________________ PHONE: ______________________

NAME OF ATTORNEY: ___________________ PHONE: ______________________

I understand that payment of charges is not contingent upon settlement from my insurance carrier and that I am responsible for any unpaid balance.

______________________________ _______________
Patient Signature Date

LA GRANGE MEDICAL CENTER/6170 JOLIET ROAD/COUNTRYSIDE, IL/60525.

ASSIGNMENT OF BENEFITS

Patient: ______________________________ SSN/ID # ______________________

Employer: _____________________________ Claim # : ______________________

Group # ______________________________

I hereby instruct and direct ______________________ Insurance Company to pay by check made out and mailed to:

La Grange Medical Center
6170 Joliet Road
Countryside, IL 60525

OR

If my current policy or rules of the insurer prohibits direct payment to the physician, I hereby instruct and direct the insurer to make out the check to me and mail it as follows:

My Name
La Grange Medical Center
6170 Joliet Road
Countryside, IL 60525

for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee. I have agreed to pay in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of the Assignment will be considered as effective and valid as the original.

I authorize release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I authorize La Grange Medical Center to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at ____________________ this ____________ day of ________________, 20__

Signature of Policyholder: ____

Signature of Claimant, if other than policyholder: __________________________

DRUG ALLERGIES

____

____

CURRENT MEDS

____

____

____

____

FAMILY HISTORY

	Father	Mother	Fathers Parents	Mothers Parents	Sibling
Heart Disease					
High Blood Pressure					
Stroke					
Cancer					
Glaucoma					
Diabetes					
Epilepsy/Convulsions					
Bleeding Disorder					
Kidney Disease					
Thyroid disease					
Mental Illness					
Osteoporosis					

HOSPITALIZATION OR PAST SURGERIES

Reason	Date	Reason	Date

Women Only: Pregnant Yes / No Planning Pregnancy Yes / No

PAST MEDICAL HISTORY

Headache ______	Lactose Intolerance ______	Depression ______
Shortness of Breath ______	Gall bladder disease ______	Gout ______
Heart Palpitations ______	Prostate Disease ______	Scarlet Fever ______
Heart Murmur ______	Bowel irregularity ______	Chronic rashes ______
Chest Pain ______	Incontinence ______	Rheumatic fever ______
Dizziness/Fainting ______	Sexual/Menstrual dysf. ______	Mumps ______
Peripheral Vascular Dx ______	Veneral disease ______	Measles ______
Allergies/Hay fever ______	Frequent infections ______	Rubella ______
Asthma ______	Hepatitis ______	Polio ______
Bronchitis ______	Anemia ______	Diptheria ______
Pneumonia ______	Arthritis ______	Tetanus ______
Ulcer ______	Osteoporosis ______	______
GI Disorder ______	Nervousness ______	______

HABITS

Smoke: Packs daily ______	Coffee: Cups daily ______	Sleep: Difficulty falling asleep ______
How Long ______	Other caffeine ______	Continuity disturbances ______
When stopped ______	Alcohol: Type/Amount ______	Snoring ______
Exercise Routine ______	Diet: Salt Intake ______	Early morning awakening ______
______	Fat Intake: ______	daytime drowsiness ______

Contact with blood or body fluid at work ______________________________

INSURANCE AUTHORIZATION AND ASSIGNMENT: I HEREBY AUTHORIZE LAGRANGE MEDICAL CENTER TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO OTHER PHYSICIANS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Date: ______________________ Signature of Patient ______________________

LaGrange Medical Healthcare, Ltd.

6170 Joliet Road
Countryside, IL 60525
708 352-0330 phone
708 352-8905 fax

January 2013

To all our patients:

Effective immediately, all patients with outstanding balances will be required to pay all, or a portion of their balance as deemed by La Grange Medical Center, prior to being seen by the doctor. When confirming an appointment, you will be reminded of your debt and asked to settle upon, and prior to your scheduled visit. If you are unable to accommodate this payment request, you may be asked to reschedule your appointment.

We at La Grange Medical Center have always tried to deliver the best medical care to our patients, and just like you, we have to continue to pay our overhead and bills in a timely fashion. Patients incurring balances, especially due to higher deductibles add to our overall outstanding debt.

In the case of new patients with deductibles, we verify your insurance prior to, or at the time of your first visit. At the time of your first visit, we will require that you give us your credit card information so that after the insurance processing of your claim, the remaining adjusted balance (co-insurance, deductibles) will be charged to your credit card upon receipt of the insurance explanation of benefits. This process usually takes between 3 to 4 weeks for the claim to go through. If this process is unacceptable to you, it is possible that you may not be seen as a patient at this clinic.

Those patients who currently have large balances will be required to work out a payment plan at the time of your visit. We will work with you to get the overall debt paid down over three monthly payments in an effort to lessen the impact of a single payment.

Sincerely,

Rick Havel
Administrator
La Grange Medical Center

Read and acknowledged by:

____

LA GRANGE MEDICAL HEALTHCARE
CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I acknowledge that I have been informed of the availability of our Notice of Privacy Practices for La Grange Medical Center or have been notified that the Notice is posted in the office waiting room for me to review.

I consent to the use or disclosure of my Protected Health Information (PHI) by La Grange Medical Center for purposes of Treatment, Payment and Health Care Operations as described in the Notice.

I understand that this consent remains in effect until I revoke it. I have the right to rescind this consent in writing at any time, but such revocation will not apply to any uses or disclosures which occurred before the effective date of the revocation.

I understand that I have the right to request restrictions in how my PHI is used or disclosed to carry out Treatment, Payment and Health Care Operations, but that LMHC is not required to agree with or grant those requests.

I understand that the Notice of Privacy Practices describes how LMHC will attempt to communicate with me regarding my PHI, and that I have the right to request a change in my preferences for confidential communications at any time.

With respect to your preferences, we ask that you take this opportunity to indicate where and how you want us to contact you regarding your test results or similar PHI by completing the checklist below (leave selection blank if not applicable). For situations when you are unavailable, please indicate whether we can leave confidential information on your voice mail, or whether we can use our discretion to discuss or leave messages regarding your PHI with the person designated below:

Method of Communication:	LMHC May Contact Me Via:	LMHC May Leave a Confidential Message On My:
Home Telephone	___Yes ___No	Home Voice Mail___
Home Fax	___Yes ___No	
Work Telephone	___Yes ___No	Work Voice Mail___
Work Fax	___Yes ___No	
Cell Phone	___Yes ___No	Cell Voice Mail___

I give my permission for LMHC to exercise its discretion in the use and disclosure of my PHI to:

____

____

YOUR DESIGNEE'S PRINTED NAME

RELATIONSHIP

I understand that I may change my preferences in writing at any time by completing the LMHC Request For Change In Confidential Communications Form and forwarding it to our Privacy Officer.

Please note that the Notice of Privacy Practices For La Grange Medical Center is subject to change and revision. If we make any revisions, paper copies of that revision will be available in our office as of the effective date, and will also be posted in our waiting room.
I hereby acknowledge all of the above:

____
PRINTED NAME

____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

Date: ______/______/______.

____
RELATIONSHIP OF PERSONAL REPRESENTATIVE TO PATIENT

For LMHC Privacy Issues, Please Contact:

La Grange Medical Healthcare
Rick Havel,
Privacy Officer
6170 Joliet Road
Countryside, IL 60525
Office Phone: 708-352-0330
Office Fax: 708-352-8905

LA GRANGE MEDICAL CENTER

PRACTICE GUIDELINES AND PATIENT FINANCIAL POLICIES

Initials	Item #	Policy
______	1	**Emergencies:** Our providers will make every effort to receive your calls and respond promptly in an emergency. If you do not receive an immediate response, you will call 911, receive paramedic intervention, and seek the nearest emergency room.
______	2	**Prescription Refills:** It is our policy that you should be responsible to know when your medications must be refilled at least a week before you run out. Medications are refilled only at the patient visit or when requested in advance through your pharmacy. We will not take weekend, walk-in, after hours or phone call refill requests. All refill requests are subject to the physicians guidelines relative to your diagnosis and compliance.
______	3	**Telephone encounters and sick patients:** Our practitioners do not treat new patients or new illnesses over the telephone. The physician may elect to treat an existing patient seeking continuing care for an existing straightforward illness over the telephone. The physician may also request that the patient make an appointment if deemed necessary. Follow up, at the request of a physician is important, and we do request strict adherence to this request.
______	4	**Information:** you agree to provide your correct name, current and correct address, cellular or other phone number, email address, insurance information, Social Security number, driver's license, or other picture identification at the time of registration or as requested by the practice at any time.
______	5	**Financial responsibility:** By these initials and your signature below, you accept financial responsibility for all charges for services rendered to you. If a minor or under guardianship, the parent or guardian accompanying the patient assumes this responsibility.
______	6	**Payment methods:** We accept cash, check, and most major credit cards. Reception staff may be contacted regarding credit cards accepted or insurance companies in which the practice participates. Cash Patients are required to pay with cash or a credit card only.

Initials	Item #	Policy
______	7	**Appointments:** Our office schedules appointments as a common courtesy for patients and in consideration of your time. Minors must be accompanied by a parent or guardian in order to be seen. We require a minimum of 24 hours (or the Friday before a Monday appointment) notice of cancellation as a courtesy to other patients seeking services. For appointments that are scheduled and cancelled the same day, we have the right to charge a $ 25.00 cancellation fee. Additionaly, scheduled surgical procedures(which require extra time) that are cancelled the same day are subject to an additional charge equal to the cost of the procedure. Upon your second (2nd) non-cancelled and/or missed appointment, a fee of $ 30.00 will be charged for non-cancelled and missed appointments, which include physician visits, scheduled labs, tests, procedures and therapy sessions. You are responsible to pay these fees prior to seeing the doctor. Two (2) non-cancelled or missed appointments within a 12 month period of time may result in discharge from the practice.
______	8	**Forms fees:** Our practice charges for additional paperwork outside the completion of the medical record. The following fees apply, and are subject to change without notice: (a) single page life insurance, legal forms, school forms, duplicate prescriptions, driver's license forms --$ 25.00 (b) multiple page legal forms, FMLA, immigration forms, AFLAC supplemental forms, disability forms (any type, any insurance) --$55.00
______	9	**Medical records:** The medical chart is the property of the practice. However, copies of your pertinent medical information are available upon request. The practice charges a fee for a copy of the record according to those published annually by the State of Illinois Comptroller's Office. This fee schedule is available upon request.
______	10	**Insurance co-payments, deductibles and coinsurance.** Insurance companies do not pay all fees and may exclude certain services from coverage. It is your responsibility to understand your insurance plan. All co-payments, deductibles, coinsurance, or non covered services are to be paid in a timely fashion according to office policies. If requested, and as a condition of service, you agree to sign an "advanced beneficiary notice" if we determine or question your insurance coverage. You accept full responsibility for all such expenses even if your insurance company is billed as a courtesy.
______	11	**Usual and Customary:** Some insurance plans may indicate that our fees are above "usual and customary." As a result your plan may reduce our fee to an "allowed amount" before calculating payment. This practice does not recognize a specific carrier's use of these terms. As such, unless we have specifically

contracted with the carrier, it is expected that you will be liable for our full fees.

Initials	Item #	Policy
______	12	**Slow insurance response:** You agree that if your insurance company takes more than 60 days to respond to your insurance claim that we shall consider your services your financial responsibility and it will be your responsibility to seek reimbursement from your insurance company.
______	13	**Auto Accidents:** Only established patients will be considered for treatment of an auto accident. Guidelines and expectations of patient liability will be given out only in the event of an encounter.
______	14	**Statement Policy:** Our office sends patient statements at the end of every month. Payments are due upon receipt of the statement for any open patient portion. Insurance delays do not alter our policy regarding financial responsibility. A late fee may be charged for patient balances that are more that 30 days old.
______	15	**Collection and Bank Fees:** Accounts more than 90 days old are subject for transfer to an outside collection agency. These agencies charge fees which include collection expense, legal fees and court costs. In addition to the principal amount owed, you agree to pay this fee, which will be added to the unpaid balance in the event your account is turned over to a collection agency or attorney to collect on an outstanding debt. Additionally, bank charges for checks which do not clear or cannot be cashed due to NSF will be passed on as a patient liability in the amount of $ 35.00 per check.
______	16	**Patient Discharge:** The practice reserves the right to discharge a patient for any reason. Please note that discharges may occur for failure to meet your obligations under this document. In addition, because of care quality considerations, the practice may discharge you for failure to comply with treatment plan(s) as outlined by your practitioner.
______	17	**Insurance Claims:** Our office submits insurance claims on your behalf. You agree to allow our practice to "accept assignment" of benefits and receive payment directly from your insurance company. In the event your insurer sends a payment for a claim from our office to you directly, you agree to immediately reimburse this practice for said amount within 10 days of postmark.

SIGNATURE PAGE

I have read and understand all the terms of this policy and by my initials and by my signature below, I attest that I fully understand each item and agree to the terms above.

Signature ______________________________ Date ______________

Printed Name ______________________________ Chart # ____________

All practice guidelines and policies may be modified, amended or changed as required at the discretion of the practice, and will become effective at the time of the noted change.

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