

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/ # _____ DATE OF BIRTH _____ GENDER M F MARITAL STATUS: S M D W

EMPLOYER _____ OCCUPATION _____

STREET _____ CITY _____ STATE _____

ZIP CODE _____ WORK PHONE _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

PHONE NUMBER _____ CELL NUMBER _____

REASON FOR VISIT: _____

HOW DID YOU HEAR ABOUT US? Please select one of the following: Referral _____

Yellow Pages Yelp Bing Yahoo Google Other _____ (please list). 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 _____

I authorize release of any information pertinent to any insurance company concerning any inquiries.

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

By providing your e-mail address, you may receive messages on clinic information or medical news.

Patient Signature

Date

DRUG ALLERGIES

CURRENT MEDS

FAMILY HISTORY

Father / Mother/ Fathers /Mothers /Sibling
Parents Parents

- 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 _____ | Diphtheria _____ |
| 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 Center and Urgent Care

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:

<u>Method of Communication:</u>	<u>LMHC May Contact Me Via:</u>	<u>LMHC May Leave a Confidential Message On My:</u>
Home Telephone	<input type="checkbox"/> Yes <input type="checkbox"/> No	Home Voice Mail <input type="checkbox"/>
Home Fax	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Work Telephone	<input type="checkbox"/> Yes <input type="checkbox"/> No	Work Voice Mail <input type="checkbox"/>
Work Fax	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cell Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cell Voice Mail <input type="checkbox"/>

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**

PRACTICE GUIDELINES AND PATIENT FINANCIAL POLICIES

- 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:** 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.
- 7 **Cash Accounts:** Payment is due at time of service. If additional services are required, i.e., labs, x-rays, or injections, these will be collected upon check out. If for some reason this is not done, you will be billed and expected to pay promptly.
- 8 **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. Appointments that are scheduled and include a surgical procedure (which require extra time) that are cancelled the same day are subject to an additional charge equal to the cost of the procedure.

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Upon your third (3rd) 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. Three (3) non-cancelled or missed appointments within a 12 month period of time may result in discharge from the practice.

- 9 **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, AFLAC supplemental forms, disability forms (any type, any insurance) --\$55.00
- 10 **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.
- 11 **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.
- 12 **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.
- 13 **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.
- 14 **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.

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- 15 **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 than 30 days old.
- 16 **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.
- 17 **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.
- 18 **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.

I have read and understand all the terms of this policy and I attest that I fully understand and agree to each item.

Signature _____ Date _____

Printed Name _____ Chart # _____