

**PATIENT INFORMATION**

Physician Dr. Curtis \_\_\_ Dr. Scurlock \_\_\_ Dr. Link \_\_\_ Dr. Rivera \_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone # \_\_\_\_\_ Home # \_\_\_\_\_

Employer \_\_\_\_\_ Employer Phone # \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_

Race \_\_\_\_\_ Ethnicity \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Ins. Subscriber \_\_\_\_\_ DOB \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SS# \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Relationship to patient \_\_\_\_\_ List **all** family members covered by this insurance, who are patients here:

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

I hereby authorize St. Charles Family Medical Center, S.C. to furnish information to insurance carriers concerning my illnesses and treatments. I also hereby assign to St. Charles Family Medical Center, S.C. all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance. This authorization shall be valid until revoked in writing.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Continued >

**Patient Financial Responsibility**

Dear Patient:

Our practice accepts insurance from many major insurance companies. As a courtesy, our office will file your claim electronically with your insurance carrier. We will require you to assign all insurance company payments directly to our office to avoid any misunderstanding regarding payment for professional services.

***You will be responsible for any portion of your insurance claim that is denied or not paid by your insurance carrier.*** Your insurance coverage is a contract between you and your insurance carrier, however, we will assist you to maximize your insurance benefits.

According to Illinois law, your insurance carrier must remit payment or deny your insurance claim within sixty (60) days of initial notice of claim. If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier & facilitating a resolution. We feel it is necessary to work together to resolve any insurance problems. All patients will be notified when their insurance carrier remits payment to our business office and you will be mailed a statement reflecting any balance due. You will be expected to remit final payment to our office within thirty (30) days of receipt of the statement. Delinquent accounts may be placed with a collection agency. In the event that your unpaid balance is turned over to a collection agency for recovery, collection and attorney fees will be added to your balance. Returned checks will incur a \$25 service fee.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and good communications. Our staff has been instructed to make every effort available to our patients to clarify any misunderstanding that they may ever have concerning an outstanding balance. We hope to possibly avoid any disagreement over payment for professional services. If you have any questions concerning our insurance policy or need assistance, please contact our business office immediately. For your convenience, we do accept Personal Checks, Visa, MasterCard and Discover.

***I have read, understood and accept my financial responsibilities for all professional services rendered.***

**PATIENT CONSENT FORM**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations.

**The patient understands that:**

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Patient (If other than patient)

\_\_\_\_\_  
Date