
2901 N. Clybourn Ave
Chicago, IL 60618
P: (773) 423-6178
F: (773) 451-8285

## Patient Information

**Name:** _____, _____, _____ **Date of Birth:** ____/____/____

(First) (Middle Initial) (Last)

**Social Security Number:** ____-___-____ **Street Address:** _____

(City) (State) (Zip)

**Home Phone:** _____-_____-_____ **Cell Phone:** _____-_____-_____ **Email:** _____

**Employment Status** *(Circle One):* Employed Unemployed Full-Time Student Part-Time Student Retired Child Other

## Demographics

| Race | Ethnicity | Religion |
|---|---|---|
| African American/Black | Hispanic/Latino | Hindu |
| Hispanic/Latino | Not Hispanic/Latino | Jewish |
| Asian | Declined to Disclose | Christian |
| Caucasian | Other: | Catholic |
| Declined to Disclose | | Declined to Disclose |
| Other: | | Other: |

## Emergency Information

**Person to Notify in Case of Emergency:** _____ **Relationship:** _____

**Home Phone:** _____-_____-_____ **Cell Phone:** _____-_____-_____

## Pharmacy Information

**Pharmacy Name:** _____ **Address:** _____

(City) (State) (Zip)

**Phone Number:** _____-_____-_____

MEDICAL & WELLNESS CENTERS
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**Health Information**

| | Yes | No | Date |
|---|---|---|---|
| Have you had the tetanus shot? | | | |
| Have you had the pneumococcal vaccine? | | | |
| Have you had the latest flu vaccine? | | | |
| When was your last colonoscopy? | | | |
| When was your last mammogram screening? | | | |
| When was your last papsmear? | | | |
| When was your last foot exam? | | | |
| When was your last eye exam? | | | |
| When was your last electrocardiogram? (EKG) | | | |
| When was your last physical exam? | | | |

Surgery History:

_____

_____

_____.

Do you have any allergies?

_____

_____

_____.

Medication List:


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_____

_____

_____.

## HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO


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If **YES**, please name the members allowed:

_____

_____

This consent was signed by: _____

(Print Name Please)

**Signature:** _____ **Date:** _____

**Witness:** _____ **Date**: _____

## Patient Financial Responsibility

As a courtesy to our patients, we have enrolled in numerous managed care insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly. However, it is not possible for us to keep track of all the individual requirements of each plan.

It is the responsibility of each patient to know the details of his or her insurance plan in addition to any lapses in insurance coverage. Any changes that occur because of insurance plan restrictions or lapses in coverage are ultimately the patient's responsibility. Unfortunately, if you do not inform us of special requirements required by your plan and we order medically necessary services, such as lab work, hospitalization, or supplies that are not covered by your plan; we may bill you directly for those charges. If current insurance coverage cannot be verified prior to each appointment, payment will be due at the time of service.

Providing the highest quality of medical care for our patients is our primary concern. We are more than willing to provide care within your insurance plan guidelines, whenever possible. With your cooperation you should be able to receive all the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care.

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By signing below, I acknowledge I have read and understand the following policies and I accept the rights and responsibilities outlined within them:

- Patient financial responsibility.
- Patient rights regarding medical records.
- Confidentiality and privacy of medical records.

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by me.

**Patent Signature: _____ Date: _____**

**Patient Printed Name: _____**

## Cancellation/No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from receiving much needed treatment. Conversely, the situation may arise when another patient fails to cancel, and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance or you do not show for your appointment, you will be charged a twenty-five ($25) dollar fee; this will not be covered by your insurance company.

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Print Name:

Signature:

Date: