

# FOX VALLEY INTERNAL MEDICINE, LLC



## Patient Registration

Date \_\_\_\_\_ Medicare # \_\_\_\_\_

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ Birthdate \_\_\_\_\_ Male Female

City & State \_\_\_\_\_ Phone (     ) \_\_\_\_\_

Zip \_\_\_\_\_ Cell (     ) \_\_\_\_\_

E-mail \_\_\_\_\_ *(Allows consent for email from FVIM)*

Employer \_\_\_\_\_ Phone (     ) \_\_\_\_\_

Address \_\_\_\_\_ Marital Status \_\_\_\_\_

City & State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse (or person to contact in emergency) \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Address \_\_\_\_\_ Phone (     ) \_\_\_\_\_

City & State \_\_\_\_\_ Zip \_\_\_\_\_

Parent (if patient is a minor) \_\_\_\_\_

Address (if different than above) \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Phone (     ) \_\_\_\_\_

I hereby authorize Fox Valley Internal Medicine to examine me (or my child) and render treatment physician feels necessary.

Signed \_\_\_\_\_ Date \_\_\_\_\_

### PLEASE READ CAREFULLY

All services are charged directly to the patient/insured. Patient/Insured is personally responsible for payment of services at time of service.

Our office will file claims if you are 1) Medicare/Blue Cross Blue Shield; 2) hospital confined; or 3) enrolled in a participating PPO Plan. All co-insurance payments and/or deductibles will be payable at time of service.

I realize that I am responsible for any elective procedure not covered by my insurance plan, or not considered medically necessary by my physician or insurance company, including, but not limited to: the weight loss clinic, cosmetic procedures, telephone consultations, etc.

I realize that I am responsible for making sure any specialist or testing recommended by FVIM is covered under my own medical plan.

Signed \_\_\_\_\_

*(I understand and agree with the above)*

# INSURANCE INFORMATION

## PRIMARY COVERAGE

Mail Claims To: \_\_\_\_\_  
(Name of insurance company)

\_\_\_\_\_  
(Complete mailing address)

Patient Information: \_\_\_\_\_  
Last Name First Name M.I. Birthdate

Name of Insured: \_\_\_\_\_  
Last Name First Name M.I. Birthdate

ID#: \_\_\_\_\_ Group# \_\_\_\_\_

## SECONDARY INSURANCE

Mail Claims To: \_\_\_\_\_  
(Name of insurance company)

\_\_\_\_\_  
(Complete mailing address)

Patient Information: \_\_\_\_\_  
Last Name First Name M.I. Birthdate

Name of Insured: \_\_\_\_\_  
Last Name First Name M.I. Birthdate

ID#: \_\_\_\_\_ Group# \_\_\_\_\_

## **AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN**

I hereby authorize Fox Valley Internal Medicine, LLC to furnish information to insurance carriers listed above concerning my illness and treatments. I hereby assign to the physician all payments for medical services rendered to me or my dependents. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. This includes but is not limited to missed appointment fees, late co-pay fees, and rebilling fees. I also agree that any expense incurred by Fox Valley Internal Medicine, LLC to collect the unpaid balance of the bill, including collection agencies, attorney fees, court costs, and other expenses, will be added to the bill if such additional services are required. In the event that my account is turned over for collections, information that is necessary for collection purposes will be forwarded to our professional collection company.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Insured person/Parent/Guardian)

## **AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE COMPANY**

I hereby authorize Fox Valley Internal Medicine, LLC to release to the insurance company(ies) listed above, any/all information acquired in the course of my or my dependent's examination and treatment.

Signed \_\_\_\_\_  
(Patient/Parent/Guardian)

# FOX VALLEY INTERNAL MEDICINE

NAME \_\_\_\_\_ DATE \_\_\_\_\_

## LIST CURRENT MEDICATIONS

<u>NAME</u>	<u>DOSE</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____

## LIST ALLERGIES TO MEDICATIONS

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

### IMMUNIZATIONS

Completed normal childhood vaccinations:

Yes  No

Year last tetanus \_\_\_\_\_

Year last Pneumovax \_\_\_\_\_

Year last influenza \_\_\_\_\_

## LIST PREVIOUS SURGERIES / SERIOUS INJURIES

<u>SURGERY / INJURY</u>	<u>YEAR</u>	<u>HOSPITAL</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

## DO YOU HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Arthritis                              | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Depression                   |
| <input type="checkbox"/> Asthma                                 | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Liver Disease                |
| <input type="checkbox"/> Cancer<br>_____ (indicate cancer type) | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Ulcer                        |
| <input type="checkbox"/> Colitis                                | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Glaucoma                     |
| <input type="checkbox"/> Diabetes                               | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Anxiety                      |
|   | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Chronic Bronchitis/Emphysema |

How much alcohol do you drink?  None  Rarely  Socially  Daily

Do you smoke?  No  1/2 Pack daily  1 Pack daily  More

# Fox Valley Internal Medicine

## Disclosure of Test Results

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient confidentiality is of utmost importance at FVIM and we prefer to give test results or other information directly to the patient. However, occasionally we are asked to release information to another individual.

### Please choose from the following options:

I want my test results / healthcare information reported ONLY directly to me.

**OR**

Fox Valley Internal Medicine has my permission to speak to myself or one of the following individuals listed below:

Name	Phone #	Relationship
1.		
2.		
3.		
4.		

- May we leave personal healthcare information on your answering machine?  Yes  No
- May we contact you at work?  Yes  No

If Yes please provide your direct work number: \_\_\_\_\_  
(Please print clearly)

### If you would like to be contacted other than by phone, please supply the following:

- Would you like your personal healthcare information faxed directly to your personal home or work fax number?  Yes  No

If YES please provide your secure personal fax number: \_\_\_\_\_  
(Please print clearly)

- Would you like your personal healthcare information sent to your personal e-mail address?  Yes  No

If YES please provide your secure personal e-mail address: \_\_\_\_\_  
(Please print clearly)

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

\*\*\*By signing this, I am giving FVIM/Achieve permission to send out any private healthcare information and that FVIM/Achieve will not be responsible for disclosure of that information.

\*\*\*I also understand it is my responsibility to update FVIM/Achieve when there are changes to any of the above information. All changes must be documented on the disclosure of test results form before we can send healthcare information out.

