Patient Registration

FOX VALLEY INTERNAL MEDICINE, LLC

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)

(OVER)

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

NAME DOSE

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

SURGERY / INJURY	YEAR	HOSPITAL
1.		
2.		
3.		
4.		
5.		

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS?

☐ Arthritis

☐ Asthma

☐ Cancer

____
(indicate cancer type)

☐ Colitis

☐ Diabetes

☐ Tuberculosis

☐ Seizures

☐ Heart Disease

☐ High Blood Pressure

☐ Kidney Disease

☐ Stroke

☐ Depression

☐ Liver Disease

☐ Ulcer

☐ Glaucoma

☐ Anxiety

☐ 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.

Fox Valley Internal Medicine, LLC

Financial Policies

1. Statements are mailed out each month. Payments are due 28 days after the statement date unless other arrangements have been made in advance.

2. If **no** payment is received by the next statement date, a non-adjustable late fee of $20.00 is assessed to the account.

3. Accounts that have not received any payments or acknowledgement for 3 consecutive months will be referred to a collection agency. A collection fee of 30-40% of the current outstanding balance will be added to the account. This service charge is non-adjustable and will be added to your outstanding balance being sent to the collection agency. In addition, any bounced or non-sufficient fund checks will receive a $25.00 penalty charge.

4. All no-show appointments will be charge a missed appointment fee; it is $25.00 for the *first* missed appointment fee. A no-show is considered an appointment to which a patient does not come and did not call to cancel 24 hours before the time of the appointment. No-show appointment fees are expected to be paid and will not be adjusted off of your account. When a patient makes an appointment, it is their responsibility to attend that appointment. Every attempt is made 1-2 days prior to inform a patient of their obligation, but sometimes we are not always able to contact the patient directly. A confirmation call is only a courtesy.

5. Co-pays for procedures performed in our office are due at the time of service unless previous arrangements have been made in advance. Any co-pay not received by close of the business day will receive a late co-payment fee of $5.00.

6. All patients are responsible to know and monitor their own insurance benefits. Important things to pay attention to are co-payments, fee for service, deductibles, telephone consultations and services not covered by your insurance plan. Except for patients who have Medicare or an insurance plan contracted by Fox Valley Internal Medicine, patients are responsible to submit their own secondary insurance claims. Our billing department will be happy to supply you with the appropriate insurance forms.

7. Patients will be charged for medical record copying following the guidelines set by the Illinois State mandate.

I understand the above stated financial policies of Fox Valley Internal Medicine, LLC. I have been given an opportunity to have all my questions answered regarding these policies.

X__________________________________

Date__________________________

Patient Informed

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