WELCOME TO OUR OFFICE, THE ELGIN CLINIC, LTD.

Patient Registration Form

Patient Information

Patient Name: _____ Sex: _____ M _____ F

Social Security#: _____ Date of Birth: _____

Address: _____ Apt: _____

City, State: _____ Zip Code: _____

Home Telephone (Primary): _____ Work: _____ Cell: _____

Email Address: _____

Employer: _____ Occupation: _____

Marital Status: _____ Married _____ Single _____ Divorced _____ Widowed _____ Separated

Spouse's Name: _____

Spouse's Employer _____ Employer Phone #: _____

If patient is a minor,

Guardian Name: _____ Relationship: _____

Date of Birth: _____ Social Security #: _____

Address: _____ Contact #: _____

_____ Email: _____

Who referred you to our office? _____

Primary Doctor _____

Primary Doctors address _____

Primary Doctors phone number _____ fax number _____

What Pharmacy do you use? _____ Address: _____

Phone Number: _____ Fax Number: _____

Emergency Contact: (person not living in your household)

Name: _____ Relationship: _____

Address: _____ Apt: _____

City, State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

Insurance

Primary Insurance Co. Name: _____

Member, Policy, or ID Number: _____ Group#: _____

Claims Address: _____ City, State: _____

Policy Holder's Name: _____ Date of Birth: _____

Address and Phone: _____

Secondary Insurance Co. Name: _____

Member, Policy, or ID Number: _____ Group #: _____

Claims Address: _____ City, State: _____

Policy Holder's Name: _____ Date of Birth: _____

Address and Phone: _____

RELEASE (Please Read Carefully)

I authorize the release of any medical information necessary to process this claim and any other future claims. I also authorize payment of medical benefits to The Elgin Clinic, Ltd. In the event that my insurance company does not cover services, I will be responsible for any unpaid balances, subject to any interest or late fees, or collection fees and/or litigation fees. The Elgin Clinic, Ltd. also reserves the right to access your prescription monitoring program report.

_____

Signature: _____ Date: _____

Relationship to Patient: _____

THE ELGIN CLINIC, LTD.

Please provide us with the following information

Name: _____ Date of Birth: _____

ALL medical conditions for which you have been treated (as many as you can think of):

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

ALL allergies that you have: _____ _____ _____

_____ _____ _____ _____

List ALL medications/OTC supplements/ Oral health agents you take:

NAME	STRENGTH	HOW MANY TIMES TAKEN A DAY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(CONTINUE ON BACK IF NECESSARY)

SURGERIES: _____ _____ _____

_____ _____ _____ _____

(CONTINUE ON BACK IF NECESSARY)

Have you had a Colonoscopy? Y or N (circle) date:_____ normal/abnormal (circle)

When did you last have blood work completed? Date: _____

FAMILY HISTORY: List health conditions (cancer, heart problems, diabetes, and depression)

Mother: _____ Father:_____

Sisters: _____ Brothers: _____

SOCIAL HISTORY: Marital status: married single divorced (circle)

Smoker: Y or N (circle) quit date_____ Alcohol: never rarely social daily (circle)

FEMALE:

GYNECOLOGIC: Date of last mammogram: _____ Normal? Y or N (circle)

Date of last pap smear date: _____ History of abnormal pap? Y or N (circle)

Date of last bone density study: _____

Birth control: none IUD pills tubal condoms patch vasectomy other (circle)

Other Doctors/providers that you see: Eye: _____ OB/GYN: _____

Heart: _____ Skin:_____ Orthoped:_____ GI:_____

Do you have an advanced directive: Y or N (circle) Name of your POA: _____

Patient Office Policies

Your Initial Visit

Please arrive 30 minutes before your appointment to complete all patient information forms. Please bring your medications and your insurance card and picture ID with you. If possible, please bring your medical records with you or the name and address of your previous physician. Any information regarding your past medical history would be helpful.

Appointments

An appointment is needed in order to be seen. We ask that you please present your insurance card to check in at every office visit. Please call us in advance so that a special time may be reserved for you. If you are unable to keep your scheduled appointment, please call at least 24 hours prior to scheduled appointment. If you are more than 15 minutes late, it may be necessary to reschedule your appointment.

A $35 fee is charged for appointments that are not canceled 24 hours in advance.

If you are under 18 years old, you need to be accompanied by a parent or guardian or have a note from them giving us permission to see you.

Payment

Any copayments and all balances must be paid in full at check in prior to being seen.

Prescriptions

Please allow up to 48 hours for any refill request to be filled. Be prepared to provide the prescription name and other information on the label.

Prescriptions for antibiotics, pain medicines, or other non-routine medications require an office visit so that a review of your chart and an examination may be completed to better determine the appropriate course of care and proper medications.

Medical Records & Release Information

If you have not signed a HIPAA "disclosure of information release form", we cannot by law speak with anyone other than the patient or parent/guardian if the patient is a minor. Please also be aware that there are some issues that cannot be discussed with a parent unless we have the permission of the minor child.

*Our office charges a fee for release of records for personal use. The first 1-25 pages $0.96/page, 26-50 $0.64, 50+ pages $0.32, from microfiche or microfile $1.60, with a handling fee of $25.55.

There will be a fee for any form to be completed outside of an office visit. One free form will be completed during any office visit, after that there will be a minimal charge. Please allow up to 48 hours for any forms/letters requested.

Signature: _____ Date: _____

Relationship to Patient: _____

The Elgin Clinic, Ltd.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **The Elgin Clinic, Ltd.** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by **The Elgin Clinic, Ltd.** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **The Elgin Clinic, Ltd.** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **The Elgin Clinic, Ltd.**

With this consent, **The Elgin Clinic, Ltd.** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **The Elgin Clinic, Ltd.** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **The Elgin Clinic, Ltd.** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **The Elgin Clinic, Ltd.** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **The Elgin Clinic, Ltd.**] to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **The Elgin Clinic, Ltd.** may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable

Authorization for Release of Information

Name of Patient _____ Date of Birth_____

The Elgin Clinic, Ltd is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information.
Check each person/entity that you approve to receive information.

☐ Voice Mail

☐ Spouse (provide name & phone number)

_____

☐ Parent (provide name & phone number)

_____

☐ Other (provide name & phone number)

_____

Description of information to be released.
Check each that can be given to person/entity on the left in the same section.

☐ Results of lab tests/x-rays

Other_____

☐ Financial
☐ Medical as follows:_____

_____

☐ Financial
☐ Medical as follows:_____

_____

☐ Financial
☐ Medical as follows _____

_____

Patient Information
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____Date _____
Signature of Patient or Personal Representative
Description of Personal Representative's Authority (attach necessary documentation)

_____

The Elgin Clinic, Ltd
1530 N Randall Road, Suite 200
Elgin, IL 60123

INSURANCE AUTHORIZATION AND ASSIGNMENT

(please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to The Elgin Clinic, Ltd and authorize The Elgin Clinic, Ltd to furnish information regarding my illness to my insurance carrier. I have been informed of HIPPA Patient Privacy Rules.
I understand that I am financially responsible for any amount(s) not paid by my insurance company. I acknowledge receipt of the HIPPA Privacy Policy.

_____ _____

Patient/Patient's Representative Signature Date