# Patient Registration

Date: ______________________ Email: _________________________________

Sex: Male______ Female_______ Date of Birth______________________________

Patient Name: ___________________________________________________________

Address: _______________________________________________________________

City: ____________________________ State _________ Zip Code: _______________

Telephone Numbers: Home: ____________________________________

Cell: ______________________________________

Work: _____________________________________

Marital Status: Married______ Divorced______ Legally Separated_______
Widowed______ Single______ Minor_______

Race: White:____ Other Pacific Islander:_____ More than one race:_____
Unreported/refused to report:_____ Black/African American:_____
American Indian/Alaska Native:_____ Asian:_____ European:_____
Unknown:_____ Other:_____ Native Hawaiian:____

Ethnicity: Hispanic/Latino:_______
Not Hispanic/Latino:_______
Unreported/refused to report:_______

Preferred Language: English:______ Spanish:______ French:_____
German:______Hindi:______ Italian:______
Russian:______Japanese:_____ Portuguese:_____

Social Security Number: __________-__________-______________

Are You Employed? Yes_____ No _____ Occupation: ____________________________

Employer’s Name & Address: ________________________________________

Employer’s Phone Number: __________________________________________

Do You Have Medical Insurance? Yes _________ No_________

Insurance Company ______________________________________________

Policy Number________________________ Group Number______________________

Medicaid Number__________________________________________

Medicare Number__________________________________________

Spouse’s Name: ______________________________________________

Spouse’s Date of Birth: ______________________________

Spouse’s Address if different from above: ________________________________

Is Spouse Employed: Yes________ No_________

Spouse’s Employer Information:

Name: ____________________________________________________________

Address: __________________________________________________________

Phone Number: _____________________________________________________

Does Your Spouse have Medical Insurance? Yes____________ No____________

Spouse’s Insurance Company: ______________________________________________

Policy Number: ___________________________ Group Number: _________________

Name and address of closest relative not living with you:

________________________________________________________________________

Phone Number: ____________________________________________________________

**IF PATIENT IS A MINOR PLEASE COMPLETE:**

Natural Mother's Name: ________________________________________________

Address: ____________________________________________________________

Phone Number: ___________________________ Date of Birth: ________________

Natural Father's Name: ________________________________________________

Address: ____________________________________________________________

Phone Number: _______________________ Date of Birth: ____________________

By submission of this form and accepting services from this facility, whether in the nature of treatment, examination or diagnostic testing, you hereby agree to be responsible for the payment of all of charges incurred in connection with your treatment, examination or diagnostic testing and/or work.

All patients must complete this form in full and allow our office to copy your insurance cards and driver's license and/or state issued identification card prior to seeing the doctor.

Our relationship is with you, NOT YOUR INSURANCE COMPANY. Insurance is a contract between you and your insurance company. If you are a member of an HMO that requires referral forms, those forms must be presented before you can see the doctor. If your policy has a deductible, a non-covered serious clause, a pre-existing condition or term or any other exclusionary language that may cause the insurer not to pay for certain treatment, examinations or testing, YOU WILL BE RESPONSIBLE FOR ANY REMAINING BALANCE.

As a courtesy, we will file a claim with your insurer; however, follow-up on that claim is your responsibility. By law, the insurer must pay, notify you that the claim is pending or deny the claim within thirty (30) days of receiving the claim.

Payment in full for all services that you receive from this facility shall be due and payable within thirty (30) days from the date that we send you OUR FIRST BILL for those services, whether or not the insurer has made a determination on any claim we submit on your behalf.

In the event that failure to pay your bill and/or statement for services rendered in full within thirty (30) days of Primary Care Joliet's mailing of **FIRST BILL** for the same to you, you will be in default of your obligation to pay us for the services rendered. At the time, you agree and will be responsible to pay all collection costs incurred, in an amount not to exceed fifty percent (50%) of the unpaid balance,

should any unpaid balance be referred to a collection agency.  In addition, should any unpaid balance due be referred to an attorney for litigation, all reasonable attorney fees and court costs shall be paid for by the undersigned as allowed by the Court.

In the event that your account is overdue and has been sent to a collection agency and/or attorney, Primary Care Joliet has the legal right to, and may disengage you from the practice until the balances owed are resolved.

Initials: ___________

I hereby authorize Primary Care Joliet to release any information acquired in the course of my examination or treatment for purpose of submitting claims to my insurer for services rendered and for the purpose of collecting any and all charges incurred as a result of the services I have received.

Initials: ____________

I hereby authorize my insurer to pay directly to this facility any and all medical/surgical benefit payable to me for services rendered. The patient or parent/guardian shall be responsible for the payment of any balance due for services rendered upon the terms and condition as set forth above.

Initials: ____________

Signature: ________________________________________

Date: _____________________

# Patient Consent

This consent is for disclosure of protected health information for purpose of treatment, operations or payment.

I understand that Primary Care Joliet may need to use and disclose information about my health or medical problems for the purposes of arranging, conducting, or referring for my treatment, for obtaining payment for the services rendered me and for the operations of the practice. I consent to the use of my information for the purpose of treatment, payment, and health care operations.

I understand that my consent is not needed if the law requires Primary Care Joliet to report some aspect of my protected health information to a government agency. Example: would include suspected abuse, communicable disease, and potential for serious bodily harm to myself or others.

I understand that I have the right to review Primary Care Joliet privacy notice, to request restrictions on the use of my information and revoke my consent at a later date.

I understand that if I withhold consent for the use of my information for the purpose of treatments, payment, or operations, Primary Care Joliet may decline to undertake my care.

Patient Signature: _______________________________________________

Print Name: _____________________________________________________

Date: ______________________________

**You have rights regarding your protected health information. You may**:

a) Request restrictions on certain uses and disclosures of protected health information, but we are not required to agree to a requested restriction
b) Request that you receive confidential communication of protected health information
c) Request to inspect and copy your own protected health information
d) Request that your information is amended
e) Request an accounting of disclosures of protected health information made by the practice in the past six (6) years
f) Request a paper copy of this notice

The practice is required to act on your request within sixty (60) days.

The practice is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.

The practice is required to abide by the terms of this notice and to provide individuals with revisions to the notice.

You may complain to the practice or the secretary of Health and Human Services if you believe that your privacy rights have been violated. File a complaint with the practice by writing Mike Lopez, Privacy Officer at 2025 S Chicago St. Joliet IL 60436. No one will attempt to retaliate against you for filing a complaint.

For more information about this notice contact Mike Lopez, Privacy Officer at
(815) 726-2200 ext. 5801

To obtain a printed copy of our complete privacy policies please ask at the reception desk.

Effective as of April 14, 2003

**I have reviewed this notice and believe I understand my right to privacy.**

Name: ______________________________________________________
Print Name

Signature or initials: __________________________________________

# Notice for Primary Care Joliet

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**
**PLEASE REVIEW IT CAREFULLY.**

Once you sign Primary Care Joliet's consent form, we may use and disclose medical information about you in order to carry out your treatment, to obtain payment for services rendered to you and to carry out the operation of the practice. Examples of how we may use and disclose information about you for providing treatment, obtaining payment and operating are:

**Patient Centered Medical Home**

Medical home means having a home base for your medical needs. It's a team of people making sure you stay healthy and get the best health care. It's where your medical team and family work together to make healthcare better for you. Having a medical home means you are at the center of the efforts to keep you healthy, you have access to your healthcare needs, an ongoing working relationship with your doctor, and your complete health record ready when you need it.

**Examples of uses and disclosures for treatment:**

- If a nurse practitioner, physician, or physician assistant at the practice refers you for a cardiac stress test and needs to call the cardiologist for results, the clinician may give your name and reason for ordering the stress test to the cardiologist's office.
- A nurse practitioner, physician, or physician assistant at the practice may call you from time to time to advise you of new alternatives to your treatment.

**Examples of uses and disclosures to obtain payment**

The practice's billing office may submit a claim form containing your name, address, social security number, diagnoses and procedures performed in our office to your insurance company.

**Examples of uses and disclosures to carry out the operation of the practice**

- The practice's nurse practitioner, physician and physician assistant may audit (read and comment upon) your chart in order to track and improve our performances in assuring that screening, tests and immunizations are done on time.
- The practice's staff may call you reminding you of upcoming appointments.
- We may leave messages at the phone number you provided, asking you to return our call.

The practice may use or disclose protected health information about you for other purposes without your consent if we are required by law to disclose to government authorities such use or disclosure may include.

- Suspected abuse such as child abuse
- Documented communicable disease

The practice will make other uses and disclosure of your protected health information only with written authorization. You may revoke such authorization.

Signature: ____________________________________ Date: __________________

# Release of Information

I authorize the following persons to receive information regarding my health care. This information may include, but is not limited to, lab/test results, confirmation of appointments, and medication that may have been called into the pharmacy.

| **Name** | **Relationship** | **Phone Number** |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Signed: ____________________________________________________________

Witnessed: _________________________________________________________

Dated: _________________

YATIN M. SHAH, M.D.
INTERNAL MEDICINE/GERIATRICS
RAM MUKUNDA, M.D.
INTERNAL MEDICINE
PARAMJIT SIKAND, M.D.
INTERNAL MEDICINE
NIRAJ Y. SHAH, M.D.
INTERNAL MEDICINE
CLARENCE ABELLA, M.D.
INTERNAL MEDICINE
MUSTAFA ALADIN, M.D.
INTERNAL MEDICINE/PEDIATRICS
SHELANE SOLT
NURSE PRACTITIONER

VICTORIA MANCKE, APN/CNP
NURSE PRACTITIONER
ALLISON CURRAN, APN/CNP
NURSE PRACTITIONER
MELISA MORALES, APN/CNP
NURSE PRACTITIONER
LINDA HUSHAW, APN/CNP
NURSE PRACTITIONER
ALISON BURCHARDT
NURSE PRACTITIONER
DIANA SIMMONS
NURSE PRACTITIONER
KAREN SHAHAN
NURSE PRACTITIONER
LIJUN HE
NURSE PRACTITIONER
MELISA MARCOTTE
NURSE PRACTITIONER
DANIELLE RATAZAK
NURSE PRACTITIONER
MELISSA SHEPHERD
NURSE PRACTITIONER
LISA SMITH
NURSE PRACTITIONER

Dear Patients,

Primary Care Joliet is dedicated to meeting the needs of our patients.
In an effort to make sure we have adequate openings for all of our patients, we are advising you of the following policy change.

NO SHOW AND CANCELLATION POLICY **- Effective August 29, 2019**

**Cancellation of an Appointment:**
If it is necessary for you to cancel your scheduled appointment, we require that you call at least 24 hours in advance.

**How to cancel your appointment:**
To cancel appointments, please call (815) 726-2200 and follow the prompts.
If you do not reach a staff member you may leave a message. Please include your name, date of birth and telephone number.

**NO SHOW:**
A "no-show" is someone who fails to show for a scheduled appointment without calling 24 hours in advance of the scheduled appointment.
A "no-show" will result in a **fee of $20.00** billed to the patient's account. These charges are not billable to your insurance and will ultimately be the responsibility of the patient. All no-show charges will need to be paid before your next appointment with Primary Care Joliet.

Thank you for your cooperation.

Primary Care Joliet

Signed: ______________________________________________

# PRIMARY CARE JOLIET FINANCIAL POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this financial policy. Please read it, ask us questions you may have, and sign in the space provided. A copy will be provided upon request.

- **Insurance:** We participate in most insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up to date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- **Co-payments, Deductibles and Co-insurances:** All co-payments, deductibles, and co-insurances must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, deductibles and co-insurances from patients can be considered fraud.
- **Non-covered services:** Please be aware that some- and perhaps all- of the services you receive may be non-covered or not considered reasonable or necessary and that you will be financially responsible for these services.
- **Proof of insurance:** We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- **Claims submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
- **Coverage changes:** If your insurance changes, please notify us before your next visit so that we can make appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
- **Return Check Fee:** $25.00
- **Nonpayment:** Please be aware if your account is over 90 days past due, and remains unpaid, we may refer your account to a collections agency and you and your immediate family members may be discharged from the practice. Partial payments will not be accepted unless otherwise negotiated. If your account is referred to a collection agency you will be responsible to pay all collection costs incurred, in an amount not to exceed fifty percent (50%) of the unpaid balance, should any unpaid balance due be referred to an attorney for litigation, all reasonable attorney fees and court costs shall be paid by the undersigned as allowed by the Court. If discharge from the practice occurs, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_______________________________________________________________

Signature of the patient or responsible party / Date

_________________________________ ____________________

Print Name Patient Account Number

**Authorization to Disclose Medical Information**
**Incoming Medical Records**

Patient's Name: ________________________________________
Date of Birth: __________________________________________
Patient Chart Number: ___________________________________

**Office Use Only:**
Date Recd: __________________
Date Completed: ______________
Completed By: _______________
Amt Charged: ________________
Patient Given Copy: ___________

**1. I hereby authorize:**
Facility Name: ______________________________________________________________________________
Facility Address: ____________________________________________________________________________
Phone Number: __________________________________ Fax Number: ______________________________

To disclose the health information on the above patient to:

| | | | | | |
|---|---|---|---|---|---|
| [ ] | Primary Care Joliet<br>2025 S. Chicago St<br>Joliet, IL 60436<br>Tel (815) 726-2200<br>Fax (314) 536-8783 | [ ] | Primary Care Joliet<br>121 Robert P. Weidling Dr<br>Wilmington, IL 60481<br>Tel (815) 726-2200<br>Fax (314) 536-8783 | [ ] | Primary Care Joliet<br>2202 Essington Rd<br>Joliet, IL 60435<br>Tel (815) 726-2200<br>Fax (314) 536-8783 |

**2. Reason for this request:**

| | | | | | |
|---|---|---|---|---|---|
| [ ] | Second Opinion | [ ] | Insurance Request | [ ] | Changing doctors |
| [ ] | Moving | [ ] | Disability | [ ] | Other: _____________ |

**3. The type and amount of information disclosed is as follows:**

| | | | | | |
|---|---|---|---|---|---|
| [ ] | Entire Medical Record | [ ] | Two Year Abstract | [ ] | Other: _____________ |

Related to services provided during the following period of time: ______________________________________
Information to be excluded from this authorization: ______________________________________________

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or records from other healthcare providers. I may also include information about behavioral or mental health services, and treatment for alcohol and drug use. **Initials: _________**

**4. The patient or the patient's representative must read the following statements:**

**A.** I understand that this authorization will expire:
[ ] Sixty (60) days from the signing; or
[ ] Upon the happening of the following events: ________________________________________
**B.** I understand that I may revoke my authorization.
**C.** I understand that authorizing the disclosure of this health information is voluntary and that I may refuse to sign this authorization and I do not need to sign this form in order to ensure treatment.
**D.** I understand that pursuant to KRS 304.17a-555-Patient's Rights of Privacy Regarding Mental Health or Clinical Dependency, my health information used under this authorization may not be shared again by the recipient of the information beyond the purpose of this authorization, without written consent to the re-disclosure.
**E.** I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the recipient and may no longer be protected by federal confidentiality rules.
**F.** I understand that from time to time Primary Care Joliet may be required to disclose medical information to a patient's insurance company for case studies, required or elective by the insurance company, which may result in a profit to the practice.

_______________________________________________ ___________________________
Signature of Patient or Legal Representative Date

_______________________________________________ ___________________________
If signed by a Legal Representative, Relationship to Patient Date

This authorization must be signed by the patient if 18 years or over. If emancipated or otherwise eligible pursuant to KRS 214.185, or by the parent or legal guardian for any other minor or by patient's representative (i.e power or attorney); or if the patient is deceased, by the executor or administrator of the estate. An order or letter of approval from the Court is needed as proof for Executor or Administrator and a MR-15 Effective 04/13/03 FCC-065

# Primary Care Joliet

3 Convenient Locations

## JOLIET MAIN OFFICE

2025 S. Chicago Street
Joliet, IL 60436
Phone (815) 726-2200
Fax (314) 536-8783
Monday – Friday 8am – 7:00pm
Saturday 9am – 1pm

## WILMINGTON OFFICE

121 Robert P. Weidling
Wilmington, IL 60481
Phone (815) 726-2200
Fax (314) 536-8783
Monday, Tuesday, Thursday 9am – 5pm
Wednesday, Friday 8am - 4pm

## JOLIET WESTSIDE OFFICE

2202 Essington Road
Joliet, IL 60435
Phone (815) 726-2200
Fax (314) 536-8783
Monday – Friday 9am – 5pm