



Patient Information

Patient's Name _____	D.O.B ____/____/____	Gender _____
Ethnicity (please circle): Hispanic / Non Hispanic	Race _____	Primary Language _____
Patient's Name _____	D.O.B ____/____/____	Gender _____
Ethnicity (please circle): Hispanic / Non Hispanic	Race _____	Primary Language _____
Patient's Name _____	D.O.B ____/____/____	Gender _____
Ethnicity (please circle): Hispanic / Non Hispanic	Race _____	Primary Language _____
Mailing Address _____		
City _____	State _____	Zip code _____

Primary Health Insurance

Insurance Company Name _____		
Identification Number _____	Group Number _____	
Policy Holder's Name _____	D.O.B ____/____/____	S.S. Number _____
Relationship to Patient _____	Employer _____	

Parent/ Legal Guardian Information

Mother's Name _____	Cell Phone Number _____	
D.O.B ____/____/____	S.S. Number _____	Driver's License Number _____
Father's Name _____	Cell Phone Number _____	
D.O.B ____/____/____	S.S. Number _____	Driver's License Number _____
Emergency Contact _____	Phone Number _____	

Parental/Legal Guardian Consent

I give my permission for my child to receive medical care as needed at the office of Fox Valley Women & Children's Health Partners. Below is a list of guardians or care takers that have my permission to accompany my child for care. They have the authority to participate deciding care plans for my child in my absence.

Name _____	Relationship to Patient _____
Name _____	Relationship to Patient _____
Name _____	Relationship to Patient _____

Signature of Parent/Legal Guardian: _____ Date: _____

HIPAA

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of the Fox Valley Women & Children's Health Partners Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

Signature of Parent/Legal Guardian: _____ Date: _____

Release and Consent

I hereby authorize the physician's of Fox Valley Women & Children's Health Partners and staff under their direction to release all medical information including test results, regarding my collection and medical treatment to my primary care physician and/or insurance company. I understand that I am financially responsible for all medical charges, whether paid or not paid by insurance, and I hereby authorize the use of this signature on all insurance submission.

Signature of Parent/Legal Guardian: _____ Date: _____



Patient Name _____

Patient ID _____

Preferred Communication

Please initial next to your preferred form of communication:

____ Email: _____

Add me to your mailing list: Yes No

____ Phone: Home _____

Cell _____

Work _____

Please list your preferred pharmacy:

Pharmacy Name: _____

Pharmacy Location and/or Phone Number: _____

Check the box next to your preferred communication for the following:

Detailed Messages

Home Cell Work Email Never Leave a Message

Lab Results

Home Cell Work Email Never Leave a Message

Prescription Information

Home Cell Work Email Never Leave a Message

Clinical Summaries

Mail to Home Email Do Not Send

Please list any person or persons with whom we MAY discuss care with or leave detailed messages including lab results:

Name

Relation

Answering machines and voicemail must have an identifying message to confirm these are your numbers. Example: "You have reached Mary Smith".

Signature of Parent/Legal Guardian: _____

Date: _____



Thank you for choosing Fox Valley Women & Children's Health Partners as your health care provider. We are committed to your treatment being successful and to a long-term relationship with you.

Please understand that payment of your bill is considered a part of your treatment.

The following is a statement of our Financial Policy, please review and initial each section.

Things to bring with you to EACH appointment:

- Health Insurance Card
- Drivers License
- Method of Payment

Appointments:

- Please inform the receptionist of any demographical changes (e.g. phone number, address, email, etc) or financial changes (e.g. insurance information, etc). Failure to notify us immediately of changes in demographical or financial information may result in denial of your medical claim(s) by your insurance provider, thus increasing your financial responsibility for any services provided by our practice.
- It is your responsibility to verify that the physician you are seeing is currently participating with your insurance plan and that you have obtained all necessary referrals **BEFORE** your scheduled appointment. Failure to confirm this may result in your responsibility for any and all charges.
- **24 hours notice is required to cancel and/or reschedule all appointments. Failure to do so will result in a cancellation fee charged to the patient.**

Minor Patients:

- The parent(s) or guardian(s) accompanying a minor are both responsible for providing current insurance information for the minor; as well as, payment of any copay or balance due.
- Parent(s) or guardian(s) must have an Authorization for Medical Treatment form signed each time a minor arrives unaccompanied for an appointment.

Medicare / Medicaid Patients:

- Medicare requires that we provide patients with a written notification (Advance Beneficiary Notice) whenever it is likely that you will be responsible for a bill.
- **Medicaid/ IDPA Patients MUST bring a current insurance card each visit.** Failure to present a current insurance card at check-in may result in rescheduling of the appointment.

Lab / Hospital Charges:

- Any service(s) provided by a lab or hospital is a contract between you and that lab or hospital. Any dispute with lab or hospital charges should be directed to and resolved by the lab or hospital; dispute resolution is not the responsibility of our practice.

Insurance:

- It is the patient's responsibility to understand their insurance coverage.
- Your insurance coverage and benefits are a contract between you and your insurance company; therefore, all disputes must be handled between you and your insurance.

Payment in full is due at the time services are rendered:

- Co-pays and all non-covered services are the insured/patient's financial responsibility and are due during the check-in process. Failure to produce payment may result in your appointment being rescheduled.
- Past due balance's are required to be paid prior to any further services provided by our office unless other arrangements have been made with our Patient Financial Services Department. Failure to pay any past due balances will result in restricted services for you and your family.

Payment Plans:

- In certain cases, our practice will consider establishing a structured payment plan. Each case is reviewed individually to determine eligibility and establishment of a structured payment plan and is at the sole discretion of the practice.
- Please contact our Patient Financial Services team to have your case considered for a structured payment plan.

Collections and Outstanding Balances:

- Delinquent accounts may be placed with a collection agency and may be subject to legal action. In the event that your unpaid balance is turned over to a collection agency for recovery or legal action is warranted, collection and attorney fees; as well as, court costs will be added to your balance.
- Returned checks will incur a \$25.00 service fee.

Disability, FMLA, School, Camp and Sports forms

- Completion of Disability or FMLA forms will incur a fee of \$25.00 for EACH completed form.
- Completing a School, Camp, or Sports form **separate from an office visit** will incur a fee of \$25.00 per form.

Medical Records (paper copy or electronic copy)

- If a paper copy is requested, the following fees will be incurred: a \$25.55 handling fee, plus a per page fee as follows: \$0.96 for pages 1-25, \$0.64 for pages 26-50 then \$0.32 per page for each page over 50. These fees are the responsibility of the patient. Within 10 business days of payment receipt, a paper copy will be provided.
- If an electronic copy is requested, the following fees will be incurred: a \$25.55 handling fee, plus a per page charge of 50% of the per page charge for paper copy. Within 3 business days of payment receipt, an USB will be provided.

Our Patient Financial Services office is open Monday–Thursday 8am to 5pm & Friday 8am to 4pm

As a courtesy to our patients, we accept Visa, MasterCard, Discover, and American Express



Please sign below to confirm that you have read and understand the Financial Policy that has been provided to you by Fox Valley Women & Children's Health Partners.

Signature _____

Date _____

HIPAA Notice of Privacy Practices

Effective as of April/14/2003

Fox Valley Women and Children's Health Partners

3310 W. Main St. Suite # 200
St. Charles, IL. 60175

Office Locations

82 Miller Rd. Suite #102
North Aurora, IL. 60542

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice may from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying “Acknowledgment” form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.