



PATIENT REGISTRATION

Patient's Name: Last: _____ First: _____ Middle: _____

Birth date: ____ / ____ / ____ Sex: M / F Social Security Number: ____ - ____ - ____

If Minor, Parent's Name: _____

Patient's Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Preferred Contact By: Phone Email Letter Preferred Language: English Spanish Other: _____

Race: ____ (1) Caucasian (2) Hispanic (3) African American (4) Other _____

Ethnicity: (1) Hispanic or Latino (2) Non-Hispanic or Latino (3) Other: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ Phone Number: _____

Relationship to Patient: _____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Effective Date: ____ / ____ / ____

Address: _____ HMO / PPO / Private / Other: _____

Policyholder's Name: _____ Birthdate: ____ / ____ / ____

Address: _____ Sex: M / F

Social Security Number: ____ - ____ - ____ Group Number: _____

Policy Number: _____ Copayment: _____ Doctor: _____

Patient's Relation to Policyholder: Self / Spouse / Child / Other: _____

Employer: _____ Address: _____ Phone: _____

List all family members (First/Last Name) under this insurance: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Effective Date: ____ / ____ / ____

Address: _____ HMO / PPO / Private / Other: _____

Policyholder's Name: _____ Birthdate: ____ / ____ / ____

Address: _____ Sex: M / F

Social Security Number : ____ - ____ - ____ Group Number: _____

Policy Number: _____ Copayment: _____ Doctor: _____

Patient's Relation to Policyholder: Self / Spouse / Child / Other: _____

Employer: _____ Address: _____ Phone: _____

List all family members (First/Last Name) under this insurance: _____

I, the undersigned, assign directly to Family Medicine for McHenry County all benefits, if any, otherwise payable for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Signed _____ Date ____ / ____ / ____

Your insurance card and copayment are due at each visit. Please notify the office of any changes.

FAMILY MEDICINE FOR MCHENRY COUNTY, S.C.
PATIENT FINANCIAL POLICIES, AGREEMENTS AND AUTHORIZATIONS

PATIENT NAME _____ **DATE OF BIRTH** _____

We are committed to providing you with the best possible medical care. Your clear understanding of the financial policies of our office is important to your professional relationship with Family Medicine for McHenry County.

INSURANCE:

Your insurance is a contract between you and your insurance company. We are not a party to this contract. It is your responsibility to understand the provisions and limitations of your policy. Not all services are a covered benefit of your particular plan. It is imperative that you check with your insurance carrier prior to your scheduled visits so that you are aware of any exclusions that apply. You are financially responsible for any non-covered services.

CONTRACTED INSURANCE PLANS:

Family Medicine for McHenry County is contracted with a significant number of HMO, POS and PPO insurance plans. We will submit charges to both primary and secondary insurance carriers. It is your responsibility to complete the patient registration form and provide us with a copy of the most current insurance card. Co-payments must be paid prior to services rendered. If there is any question regarding coverage, benefits or payment for services provided, it is your responsibility to resolve this.

NON-CONTRACTED INSURANCE PLANS:

You are responsible for payment in full at time of service if Family Medicine for McHenry County does not have a contractual agreement with your insurance company. If you provide us with complete billing information and a copy of the most current insurance card, we will submit the charges on your behalf to your insurance carrier for reimbursement to you.

NO INSURANCE:

If you are uninsured, you are responsible for payment at time of service.

We do not file claims for accidents. Payment is required at time of service.

MEDICARE-ILLINOIS PUBLIC AID-WISCONSIN PUBLIC AID:

You must present your card at every office visit. If a co-payment applies it must be paid at time of service. We will file to insurance secondary to Medicare.

WORKMEN'S COMPENSATION:

You must provide Family Medicine for McHenry County with all information to properly submit charges to the appropriate payer. If a claim is not paid in three months it becomes the patient's responsibility.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby assign direct payment of benefits to Family Medicine for McHenry County, S.C. for services rendered. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE COMPANY.** I also understand that any expense incurred by Family Medicine for McHenry County, S.C. 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.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION:

I hereby authorize use and disclosure of my personal health information for the purposes of providing treatment to me, to secure payment of benefits or for the purposes of conducting the healthcare operations of Family Medicine for McHenry County, S.C. This authorization provides that Family Medicine for McHenry County, S.C. may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agents.

PRIVACY POLICY:

I acknowledge having received a copy of "Notice of Privacy Practices". My rights including the right to see and copy my record, to limit disclosures of my health information and to request an amendment to my record is explained in the policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent Family Medicine for McHenry County, S.C. has already made disclosures with my prior consent.

Patient or Authorized Person Signature / **Relationship if other than Patient** / **Date**

Please see [our website](#) to authorize release of your medical and/or account information.

I authorize the release of my medical and/or account information including secure messaging and patient portal to:

Name _____ Relationship _____ Date _____