NORTHWEST SUBURBAN MEDICAL GROUP

Patient's Name: _____ Date of Birth: _____ □Male □ Female

Social Security #: _____ Marital Status: □Single □Married □Divorced □Widowed

Home Address: _____Apt #: _____

City: _____ State: _____ Zip: _____ Email: _____

Home # _____ Cell Phone: _____ Ethnicity: □ Latino □Non-Latino

Race: □Asian □African American □American Indian □Native Hawaiian □Pacific Islander □White □Unreported

Emergency Contact:_____ Relationship: _____

Emergency Contact Phone #: _____

INSURANCE INFORMATION

Primary Insurance Company: _____

ID #: _____ Group #: _____

Secondary Insurance Company: _____

ID #: _____ Group #: _____

POLICY HOLDER IF DIFFERENT FROM PATIENT

Policy Holders Name: _____ Date of Birth: _____ □Male □ Female

SS#: _____ Phone #: _____ Relationship to Patient:_____

SOCIAL HISTORY

Recreational Drug Use? □Yes □No Type:_____

Tobacco Use? □Yes □No Type:_____ How many per day:_____ Packs/cigarettes (circle one)

# of years using? _____ Last used:_____

Alcohol Use? □Yes □No □Socially # of drinks _____ (check one) □ per day □Per week □Per month

Caffeine Use? □Yes □No Type: _____ # cups per day _____

SURGICAL HISTORY: (*If applicable, please check the box and enter the year*)

Condition	Year	Condition	Year	Condition	Year	Other:
□Eyes (laser/glaucoma/cataracts)		□Stomach/intestine/colon		□Shoulder/feet/hands		
□Ears		□Varicose Veins		□Spine/Back/Neck		
□Sinus/Nasal Septum		□Tubal Ligation		□Hips / Knees		
□Tonsil/Adenoids		□Hemorrhoids		□Prostate / Vasectomy		
□Thyroid		□Hernia		□Uterus/Hysterectomy		
□Heart		□Gallbladder		□C-section		

PAST MEDICAL HISTORY (*If applicable to YOU, please check the box*)

□Allergies/Hay Fever	□Diabetes	□Hernia	□Skin Disease/Sores
□ Anemia	□ Depression	□Herpes	□Sleep Problems
□Anxiety Problem	□Ear/Hearing Problems	□High Blood Pressure	□Stomach/Digestive Disease
□Arthritis	□Eating Disorder	□High Cholesterol	□Stroke
□Asthma/wheezing	□Eye/Vision Problems	□HIV/AIDS	□Thyroid Disease
□Back pain	□Foot Problems	□Kidney Disease/Stones	□Tuberculosis or +TB Test
□Bleeding Disorder	□Gallbladder Stones/Disease	□Liver Disease	□Urinary Problem
□Blood Transfusion	□Gastritis/Ulcer	□Lung Disease	□Crohn's Diseases
□Bone/joint Injuries	□Gout	□Menstrual Problems	Other:
□Cancer, type?	□Headaches/Migraines	□Mental Illness	
□Chicken Pox	□Heart Disease	□Osteoporosis	
□Convulsions/Seizures	□Heart Rhythm Problem	□Pneumonia	
□Dementia/Memory Loss	□Hemorrhoids	□Prostate Disorder	
□Dental/ Oral Disease	□Hepatitis	□Sexually transmitted Disease	

Drug Allergies? □Yes □No List:_____ Reaction:_____

Current Medications: Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of Drug and Dose (strength)	Directions of Medication (how many daily)

FAMILY HISTORY:

Condition	Relationship	Condition	Relationship	Other (list relationship):
□Cancer/type		□Rheumatoid Arthritis		
□Diabetes		□Thyroid Issues		
□Congestive Heart Failure		□Osteoporosis		
□Heart Disease		□Asthma/ COPD		
□High Blood Pressure		□Alzheimer's Disease		
□High Cholesterol		□Alcoholism		
□Stroke		□Seizures		
□Kidney Disease		□Migraines		
□Chronic Lung Disease		□Depression		

Family Member	Alive or Deceased	Age at Death	Cause Of Death
Mother			
Father			
Siblings			
Children			

Patient Name:_____ **Date of Birth:**_____

Patient Financial Agreement and Acknowledge of Privacy Practice

- **Co-Payments**: Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit. ***Initials:*** _____
- **Deductible Payments**: if your insurance requires you to meet a deductible before services are covered, payment must be made at the time of service. A $100.00 payment will be due at the time of service. Please note the $100.00 payment does not constitute payment in full and any additional balance must be paid upon receiving notification from our practice. ***Initials:*** _____
- **Claims Submission**: we will submit your claims and assist you in any way we reasonably can to help get your claims paid. Payment from your insurance company is expected within 45 days. After 45 days, we will look to you for payment in full. You will be responsible for all non-covered services according to Medicare guidelines. We must have a copy of your most recent cards and any secondary insurance or supplement you may have. Accounts that are 90 days past due are subject to being sent to a collection agency or small claims court for unpaid bills. If we receive notification that you are not eligible for coverage or we are not contracted with your insurance, you will be responsible for all charges incurred. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. ***Initials:*** _____
- **Preventative Care Services**: Routine exams are not always covered by your insurance. Please be aware that if an additional problem is addressed at the time of your visit, a co-pay, deductible, or office visit fee may be charged. If services are denied for payment by your insurance or you have failed to provide us with your correct insurance information, you will be responsible to pay for these services. ***Initials:*** _____
- **Cash Pay Patients**: the amount you pay for today's scheduled office visit may not be your final payment. Other costs that may be accrued for today's appointment are including, but are not limited to, laboratory tests, x-ray tests, any injections, special procedures, or additional office visit charges. ***Initials:*** _____
- **Laboratory Bills**: any laboratory procedures that are ordered during today's visit will be billed to you directly by the laboratory. Please contact the laboratory directly for any questions regarding your lab bill. ***Initials:*** _____
    - **Missed Appointments/ No Shows**: Please note a $25.00 cancellation fee will apply for missed appointments or failure to cancel within 24 hours prior to your scheduled appointment time, these charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment. ***Initials:*** _____

*****If at any time you should experience hardship and need to make special payment plan arrangements, please contact our billing office.

Assignment of Benefits: I hereby assign my insurance or other third-party carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer (for employer-sponsored/paid for claims). I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am a guarantor for. ***Initials:*** _____

Acknowledgment of Receipt of Notice of Privacy Practices: I hereby acknowledge that I have been offered a copy of Northwest Suburban Medical Group's Notice of Privacy Practices. I have been advised that a copy of the current notice will be posted in the reception area and that any amended Notice of Privacy Practices will be available at each appointment. ***Initials:*** _____

CONSENT FOR TREATMENT: I hereby authorize the physicians, mid-level providers, nurses, medical assistants, and other Practice staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable. ***Initials:*** _____

I have read and understood the above statements. I agree to comply with the financial policies of the office, and I am financially responsible for my account. I have read and understood the Assignment of Benefits and Acknowledgement of Receipt of Notice of Privacy Practices. I have read and give consent for treatment.
I certify that this form has been fully explained to me, that any blank lines have been filled in, and that any questions I have had about the service have been answered to my satisfaction

_____ _____ _____
Signature of Patient /Guardian if Minor (Relationship of the patient if minor) Date

HIPAA Acknowledgement and Communication Form

I acknowledge that I received a Northwest Suburban Medical Group S.C, Notice of Privacy Practices. We routinely call patients for the following reasons: Schedule appointments, appointment reminders, test results, and when replying to your questions and/or concerns.

If we attempt to contact you and you are not available:

	Yes	No
Leave information on voicemail		
Leave information with family members		

I grant Northwest Suburban Medical Group S.C. permission to discuss my care with the following:

_____ _____ _____
Name Relationship Phone Number

_____ _____ _____
Name Relationship Phone Number

_____ _____ _____
Name Relationship Phone Number

Updated: 01/01/2022