SHOREWOOD FAMILY MEDICINE

ADULT PATIENT INFORMATION

Please fill form **COMPLETELY. USE BLACK INK**

Patient Name:	First Middle Initial Last	☐ **M** ☐ **F**	**DOB:**	
Marital status:	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		**SS #:**	
Street Address:	Street City State Zip code			
Race:	☐ White ☐ African American ☐ Hispanic/Latino ☐ American Indian ☐ Native Hawaiian ☐ Other ☐ Refused			
Language Preference:	☐ English ☐ Chinese ☐ French ☐ German ☐ Italian ☐ Japanese ☐ Spanish ☐ Other ☐ Refused			
Employer:			**Employer Phone:**	
Employer Address:				

Please **circle** your preferred primary form of communication below

Home Phone #:		**Call First**	☐ Ok to leave detailed message ☐ Leave message with call back number only
Cell Phone #:		**Call First**	☐ Ok to leave detailed message ☐ Leave message with call back number only
Other #:		**Call First**	☐ Ok to leave detailed message ☐ Leave message with call back number only
Work Phone #:		**Call First**	☐ Ok to leave detailed message ☐ Leave message with call back number only
E-Mail Address:		By disclosing your email and phone numbers, you give agents of Shorewood Family Medicine permission to contact you by these methods.	

With Whom We May Discuss Your Detailed Medical Care

☐ No one

Name:		**Relationship:**		**Phone:**	
Name:		**Relationship:**		**Phone:**	
Name:		**Relationship:**		**Phone:**	

By disclosing the above person(s), I hereby give permission to Shorewood Family Medicine to disclose and discuss any information related to my medical treatment with the above family member(s) and / or close personal friends.

Emergency Contact:		**Relationship:**		**Phone #:**	
Preferred Pharmacy:		**Location:**			
How did you find us?					

PATIENT Signature_____ Date_____

SHOREWOOD FAMILY MEDICINE

CHILD PATIENT INFORMATION

Please fill form **COMPLETELY. USE BLACK INK.**

CHILD INFO	**Patient (child) Name:**	First Middle Initial Last	☐ M ☐ F	**DOB:**		
	Other child patient:	First Middle Initial Last	☐ M ☐ F	**DOB:**		
	Child's address:	Street City State Zip code				
PARENT INFO	**Parent/Guardian Name:**	First Middle Initial Last	☐ M ☐ F	**DOB:**		
	Marital status:	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		**SS #:**		
	Street Address:	Street City State Zip code				
	Race:	☐ White ☐ African American ☐ Hispanic/Latino ☐ American Indian ☐ Native Hawaiian ☐ Other ☐ Refused				
	Language prefer:	☐ English ☐ Chinese ☐ French ☐ German ☐ Italian ☐ Japanese ☐ Spanish ☐ Other ☐ Refused				
PARENT INFO	**Employer:**			**Phone:**		
	Address:					

Please **circle** your preferred primary form of communication below

Home Phone #:		**Call First**	☐ Ok to leave detailed message ☐ Leave message with call back number only
Cell Phone #:		**Call First**	☐ Ok to leave detailed message ☐ Leave message with call back number only
Cell Phone #:		**Call First**	☐ Ok to leave detailed message ☐ Leave message with call back number only
Work Phone #:		**Call First**	☐ Ok to leave detailed message ☐ Leave message with call back number only
E-Mail Address:		By disclosing your email and phone numbers, you give agents of Shorewood Family Medicine permission to contact you by these methods.	

Besides Yourself, With Whom We May Discuss Your Child's Detailed Medical Care

☐ No one

Name:		**Relationship to child:**		**Phone:**	
Name:		**Relationship to child:**		**Phone:**	

By disclosing the above person(s), I hereby give permission to Shorewood Family Medicine to disclose and discuss any information related to my child's medical treatment with the above family member(s) and / or close personal friends.

Emergency Contact:		**Relationship to child:**		**Phone #:**	
Preferred Pharmacy:		**Location:**			
How did you find us?					

Parent/Gaurdian Signature_____ Date_____
(same as above)

Shorewood Family Medicine
Our Financial Policy

Thank you for choosing **Shorewood Family Medicine** for your medical needs. We are committed to providing you with excellent care and friendly service. Our financial arrangements are based on an open and honest discussion of services and fees. It is your financial obligation to pay for all rendered services and applied fees.

Payment Terms and Conditions:

- All new patients will provide a $50 deposit **prior** to their first visit/appointment. This deposit will be refunded after their first visit/appointment or applied to a cancelled / missed / rescheduled appointment **with less than a 24 business hour prior notice.**
- Co-pay is due prior to service (a non-payment fee may apply)
- **Payment due-in-full upon receipt of invoice for individual and family prior to new appointment**
- Late fees apply to all balances over 30 days
- We accept Visa, MasterCard & Discover (debit/credit), cash or check

Other Financial Information:

- Cancelled / Missed / Rescheduled Appointments **with less than a 24 business hour prior notice**, will be charged a fee for the "Did Not Keep Appointment" (DNKA)
- Handling and copy fees are charged for all requests of Medical Records
- The undersigned also agrees 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.
- A charge will be assessed on all non-sufficient funds (NSF) checks and discontinued auto-payment agreements

Patient Responsibility:

- Know your insurance coverage. Your insurance policy is a contract between you and your insurance company. The quality of insurance policies varies greatly; therefore, we cannot guarantee coverage due to the complexities of insurance contracts.
- Provide us with complete and accurate medical insurance information.
- Insurance information given will be used to submit claims on your behalf. If this information is not accurate and payment is not made by the insurance carrier, it is the patient's responsibility to fulfill the financial obligation of the rendered services.
- If you have more than one policy for your family, it is your responsibility to accurately report to us who is considered Primary and Secondary. You need to notify each insurance company of all existing policies.

Minors (under the age of 18):
Payment for services rendered to minors is the responsibility of the adult accompanying that minor.

Financial Consent:
The patient (account holder) agrees to be fully responsible for total payment for all services rendered.

I understand and agree to this Financial Policy.

_____ _____
Signature of patient/account holder Date

_____
Printed name

SHOREWOOD FAMILY MEDICINE

INSURANCE

Insurance Information (Required)											
Primary Insurance :			**Policy ID:**			**Group #:**					
Policy Guarantor (Last Name):				**(First Name):**			**(M.I.):**				
Date of Birth:		**Gender:**		**Relationship to Insured:**			**Copay:**				
Secondary Insurance Information											
Secondary Insurance:			**Policy ID:**			**Group #:**					
Policy Guarantor (Last Name):				**(First Name):**			**(M.I.):**				
Date of Birth:		**Gender:**		**Relationship to Insured:**			**Copay:**				
Tertiary Insurance Information (Required)											
Tertiary Insurance :			**Policy ID:**			**Group #:**					
Policy Guarantor (Last Name):				**(First Name):**			**(M.I.):**				
Date of Birth:		**Gender:**		**Relationship to Insured:**			**Copay:**				

As you may be aware, medical insurance is becoming extremely complex. We are always available to answer your questions; however, **your insurance policy is a contract between you and your insurance company**. As a medical provider, we are not party to that agreement. We accept most insurance carriers but check with your insurance carrier to be sure that we are an in network provider under your plan. Call your insurance carrier in advance of your appointment for details of your plan.

I am **UNINSURED** and do not have any insurance coverage _____
Initials

Assignment & Release

I, the undersigned, certify that I (or my dependent) has insurance coverage with the above plan(s) and assign directly Shorewood Family Medicine all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize Shorewood Family Medicine to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient (or Guardian) Signature_____ Date_____

Printed Name _____

Shorewood Family Medicine

Vincent R. Benig, M.D.

Family Practice

Insurance Card Template

This form is a reminder to bring your insurance cards and photo ID to all appointments.

Primary Insurance Card Front

Primary Insurance Card Back

Secondary Insurance Card Back

Secondary Insurance Card Back

Photo ID

Shorewood Family Medicine
Vincent R. Benig, M.D.
Family Practice

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Shorewood Family Medicine** 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 **Shorewood Family Medicine** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Shorewood Family Medicine 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 **Vincent Benig, M.D.**

With this consent**, Shorewood Family Medicine** 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 calls pertaining to my clinical care, including laboratory test results, among others

With this consent, **Shorewood Family Medicine** 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, **Shorewood Family Medicine** 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 **Shorewood Family Medicine** 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 **Shorewood Family Medicine** 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, **Shorewood Family Medicine** may decline to provide treatment to me.

_____

Print Patient's Name

_____ _____

Signature of Patient or Legal Guardian Date

Shorewood Family Medicine

Vincent R. Benig, M.D.

Family Practice

Patient Credit Card on File Agreement –AVOID Late Payment Fees

We have implemented a policy which enables you to maintain your credit card information securely on file with Shorewood Family Medicine. In providing us with your credit card information, you are giving Shorewood Family Medicine permission to automatically charge your credit card on file for your co-pays, outstanding balance and fees (for the cardholder or any other person(s) you have listed on this form). This agreement will remain in effect until the expiration of the credit card account. You you may revoke this form at any time by submitting a written request. **It is the responsibility of the cardholder to update changes to the credit card with our office promptly.**

Co-pays*:* Co-pays are due at time of the office visit.

Outstanding Balance: If your insurance provider has paid their portion of your bill [or any other patient(s) you have listed on this form] and there is an outstanding balance owed, Shorewood Family Medicine will notify you via mail and/or email. If after the initial billing cycle, we do not receive a response from you or your payment in full, any balance owed will be charged to your credit card in lieu of a second statement and late payment fee. A copy of the charge will be sent by email (if applicable). This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Multiple Users: This card will only be authorized for the use of the credit card holder or any person(s) listed below.

I authorize Shorewood Family Medicine *to charge co-pays, fees, and outstanding balances on my account to the following credit card:*

☐ **Visa** ☐ **MasterCard** ☐ **American Express** ☐ **Discover**

Credit Card Holder Name: _____
(Please Print)

Last 4 digits of Credit Card: _____ CVV: _____ Expiration Date: _____/_____

If you wish to leave this credit card on file for OTHER patients, please print names below:

Patient Full Name: _____
(Please Print)

Patient Full Name: _____

Patient Full Name: _____

Patient Full Name: _____

NOTE: THIS CREDIT CARD IS NOT SAVED IN YOUR ACCOUNT FOR FUTURE USE UNTIL A CREDIT CARD TRANSACTION OCCURS IN OUR SYSTEM.

Card Holder's signature: _____ Date: _____

Shorewood Family Medicine

Vincent R. Benig, M.D.

Family Practice

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

You may refuse to sign this document.

I, _____, have received/read a copy of this office's Notice of Privacy Practices.
Please Print Name

_____ _____

Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign.
Communications barriers prohibited obtaining the acknowledgement
An emergency situation prevented us from obtaining acknowledgement
Other (Please Specify) _____

Shorewood Family Medicine

NOTICE OF PRIVACY POLICY

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 practice creates a medical record of your health information in order to treat you, receive payment for services delivered, and to comply with certain policies and laws. We are also required by law to provide you with this Notice of our legal duties and privacy practices. In addition, the law requires us to ask you to sign an Acknowledgment that you received this Notice.

We are required by federal and state law to maintain the privacy of your medical information. Medical information is also called "protected health information" or "PHI." We are also required by law to notify you if you are affected by a breach of your unsecured PHI.

This is a list of some of the types of uses and disclosures of PHI that may occur:

Treatment: We obtain health information, or PHI, about you to treat you. Your PHI is used by us and others to treat you. We may also send your PHI to another physician, facility, or counselor to which we refer you for treatment, care, procedures, or testing. We may also use your PHI to contact you to tell you about alternative treatments, or other health-related benefits we offer. If you have a friend or family member involved in your care, we may give them PHI about you.

Payment: We use your PHI to obtain payment for the services that we render. For example, we send PHI to Medicaid, Medicare, or your insurance plan to obtain payment for our services.

Health Care Operations: We use your PHI for our operations. For example, we may use your PHI in determining whether we are giving adequate treatment to our patients. From time-to-time, we may use your PHI to contact you to remind you of an appointment.

Legal Requirements: We may use and disclose your PHI as required or authorized by law. For example, we may use or disclose your PHI for the following reasons:

Public Health: We may disclose your health information to prevent or control disease, injury or disability, to report births and deaths, to report reactions to medicines or medical devices or to report suspected cases of abuse or neglect.

Health Oversight Activities: We may use and disclose your PHI to state agencies and federal government authorities when required to do so. We may use and disclose your health information in order to assist others in determining your eligibility for public benefit programs and to coordinate delivery of those programs. For example, we must give PHI to the Secretary of Health and Human Services in an investigation into our compliance with the federal privacy rule.

Judicial and Administrative Proceedings: We may use and disclose your PHI in judicial and administrative proceedings. Efforts may be made to contact you prior to a disclosure of your PHI to the party seeking the information.

Law Enforcement: We may use and disclose your PHI in order to comply with requests pursuant to a court order, warrant, subpoena, summons, or similar process. We may use and disclose PHI to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency.

Avert a Serious Threat to Health or Safety: We may use or disclose your PHI to stop you or someone else from getting hurt.

Work-Related Injuries: We may use or disclose PHI to an employer if the employer is conducting medical workplace surveillance or to evaluate work-related injuries.

Coroners, Medical Examiners, and Funeral Directors: We may use or disclose PHI to a coroner or medical examiner in some situations. For example, PHI may be needed to identify a deceased person or determine a cause of death. Funeral directors may need PHI to carry out their duties.

Armed Forces: We may use or disclose the PHI of Armed Forces personnel to the military for proper execution of a military mission. We may also use and disclose PHI to the Department of Veterans Affairs to determine eligibility for benefits.

National Security and Intelligence: We may use or disclose PHI to maintain the safety of the President or other protected officials. We may use or disclose PHI for the conduct of national intelligence activities.

Correctional Institutions and Custodial Situations: We may use or disclose PHI to correctional institutions or law enforcement custodians for the safety of individuals at the correctional institution, those that are responsible for transporting inmates, and others.

Research: You will need to sign an Authorization form before we use or disclosure PHI for research purposes except in limited situations. For example, if you want to participate in research or a clinical study, an Authorization form must be signed.

Fundraising: We do not engage in fundraising activities. We do not engage in marketing activities, and need your authorization to do so.

Immunizations: If we obtain and document your verbal or written agreement to do so, we may release proof of immunization to a school where you are a student or prospective student.

Illinois law: Illinois law also has certain requirements that govern the use or disclosure of your PHI. In order for us to release information about mental health treatment, genetic information, your AIDS/HIV status, and alcohol or drug abuse treatment, you will be required to sign an Authorization form unless state law allows us to make the specific type of use or disclosure without your authorization.

Your Rights: You have certain rights under federal and state laws relating to your PHI. Some of these rights are described below:

Restrictions: You have a right to request restrictions on how your PHI is used for purposes of treatment, payment and health care operations. We are not required to accommodate to your request, except as required by law. The practice is required to comply with your request for restrictions on the use or disclosure of your PHI to health plans for payment or health care operations purposes when the practice has been paid out of pocket in full and the practice has been notified of the request for restriction in writing, and the disclosure is not required by law.

Communications: You have a right to receive confidential communications about your PHI. For example, you may request that we only call you at home. If your request is reasonable, it may be accepted.

Inspect and Access: You have a right to inspect your health information. This information includes billing and medical record information. You may not inspect your record in some cases. If your request to inspect your record is denied, we will send you a letter letting you know why and explaining your options.

You may have a paper or electronic copy of your PHI in most situations. If you request a copy of your PHI, we may charge you a fee for making the copies and mailing them to you, if you ask us to mail them.

Amendments of Your Records: If you believe there is an error in your PHI, you have a right to request that we amend your PHI. We are not required to agree with your request to amend.

Accounting of Disclosures: You have a right to receive an accounting of disclosures that we have made of your PHI for purposes other than treatment, payment, and health care operations, or release made pursuant to your authorization.

Copy of Notice: You have a right to obtain a paper copy of this Notice, even if you originally received the Notice electronically. We have also posted this Notice at our offices.

Complaints: If you feel that your privacy rights have been violated, you may file a complaint with us by calling our Privacy Officer at (815)729-1010. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, DC if you feel your privacy rights have been violated.

Authorizations: We are required to obtain your written Authorization when we use or disclose your PHI in ways not described in this Notice or when we use or disclose your PHI as follows: for marketing purposes, for the sale of your PHI, or for uses and disclosures of psychotherapy notes (except certain uses and disclosures for treatment, payment, or health care operations), You may revoke your Authorization at any time in writing, except to the extent that we have already acted on your Authorization.

We are required to abide with terms of the Notice currently in effect, however, we may change this Notice. If we materially change this Notice, you can get a revised Notice by stopping by our office to pick up a copy. Changes to the Notice are applicable to the health information we already have.

EFFECTIVE DATE: September 30, 2015