Advance Midwest Medical
1585 N. Barrington Road
Doctors Building 2 – Suite 501
Hoffman Estates, IL 60169

REGISTRATION FORM

(Please Print)

Today's Date:	PCP: ☐ Dr. Rajiv Sood

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs	☐ Miss ☐ Ms.
			Marital status:	Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Social Security number:	
City:	Home phone number:	( )
	Mobile phone number:	( )
State:	Work phone number:	( )
ZIP Code:	Email address:	@

PHARMACY PREFERENCE

Preferred Local Pharmacy:	Town - Location of Pharmacy:	Closet Intersection to Pharmacy:
Preferred Mail Order Pharmacy:		

☐ Express Scripts ☐ Prime Mail ☐ Prime Therapeutics ☐ CVS Caremark ☐ Aetna Home Delivery ☐

☐ Other:

Chose clinic because/referred to clinic by (Please check one box):

☐ Family	☐ Location	☐ Friend :	☐ Internet	☐ Referred by Doctor:	
☐ Hospital / Referral Line		☐ Insurance plan	☐ Other:		

Other family members seen here:

IN CASE OF EMERGENCY

Name of local Emergency Contact:	Relationship to patient:	Mobile phone no.:	Home/Work phone no.:
1)		( )	( )
2)		( )	( )

FOLLOWING INDIVIDUALS SHALL HAVE ACCESS MEDICAL INFORMATION

Name of Individual:	Relationship to patient:
1)	
2)	
3)	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Advance Midwest Medical to release any information required to process my claims for payment.

Patient or Legal Guardian Signature _____ *Date*

Rajiv K. Sood, MD
Advance Midwest Medical, S.C.
1585 N. Barrington Road
Doctors Bldg 2 – Suite 501
Hoffman Estates, IL 60169-5020
Tel: (847) 490-8900 Fax: (847) 490-8999

Financial Payment Policy

I hereby assign, transfer, and send over to Advance Midwest Medical all the rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand I am financially responsible for all charges whether they are covered by my insurance.

I am aware that my co-pay is expected at the time of service. Insurance information on file will be billed first. It is my responsibility to provide Advance Midwest Medical with any changes or updates in my insurance coverage. In the event insurance coverage, changes and/or an insurance carrier determined the billed services are not covered, it is my responsibility to contact the insurance company to clear up coverage denials. Any unpaid amount by the insurance company becomes my responsibility to pay Advance Midwest medical.

In the event no insurance is available, payment for services rendered on my behalf and/or my beneficiaries becomes by responsibility.

I also acknowledge:

1. Applicable co-pays are due at the time of service
2. Returned checks to out office for insufficient funds will be assessed a $35 fee
3. No call no show appointments or cancellations in less than 24 hours will be charged a $25 Fee
4. Charges for medical records will be due when picked up.
5. Unpaid balances after 60 days are considered delinquent and will transferred to our collection agency.
6. Any applicable collection fees such as delinquent interest, collection agency fees, and legal fees incurred by Transworld Systems in attempting to collect unpaid balances will be my responsibility.

Responsibility Party Name: _____ SSN: _____

Responsible Party Phone Number: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. This notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

This consent was signed by:

_____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

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Tel: 847.490.8900 Fax: 847.490.8999
www.AdvanceMidwestMedical.com

HIPPAA Medical Release of Information

Patient Name_____ DOB ___/_____/_____

☐ Send via US Postal Mail ☐ Fax to (847) 490-8999 ☐ Please Give to Patient

☐ Incoming to	☐ Specified Facility (Outgoing Information)
Advance Midwest Medical, S.C. **1585 N. Barrington Road** **Doctors Bldg. 2 – Suite 501** **Hoffman Estates, IL 60169-5020** **Tel: (847) 490-8900 Fax: (847) 490-8999**	

I hereby give my consent and authorize to the above marked facility to have access to my the following:

Medical Records, Physician Notes, Laboratory Reports, Pathology Reports, Radiology/Diagnostics Reports, Procedural/Operative Reports, Immunization Records, Mental Health Records and Consultation Report

I understand that I may revoke this consent in writing at any time, although not retroactively, and that upon fulfillment of the above request medical information or the lapse of 12 months from the date of signature, whichever comes first, this consent will automatically expire without my expressed revocation. A photocopy of this authorization shall be as valid as the original.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed as provided in 45 C F R 165.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. The patient's medical record is privileged information, which is protected by various State and Federal Laws. Such information may not be further disclosed to other persons or entities without a separate written authorization from the patients.

I understand that the information in my health record may include information relating to sexually transmitted diseases, such as the Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

Patient must sign unless he/she is a minor under 18 or is unable to sign. If signature is not of a patient, indicate the relationship to patient.

Purpose of the release/disclosure to other person/origination

☐ *Continuation of Care/Transfer of Care* ☐ *Attorney/Legal* ☐ *Insurance Company* ☐ *Works Compensations*
☐ *Other:*_____

Patient Signature: _____ *Date:* _____/_____/_____

Relationship to Patient:
☐ *Self* ☐ *Parent* ☐ *Adult Child* ☐ *Sibling* ☐ *Spouse* ☐ *Legal Guardian* ☐ *Health Care POA*