ICPR Family Practice
Care • Prevent • Rejuvenate.

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PATIENT REGISTRATION

PATIENT INFORMATION:

Name_____DOB_____
Last First M

Address_____

City _____ State_____ Zip_____

Phone _____ Daytime Phone _____SS#_____

Sex: M or F Marital Status _____ email address_____

Patient's Employer _____

Employer Address_____Employer Phone_____

Race_____ Ethnicity_____ Preferred Language_____

Name and Address of person who referred you_____

How did you hear of ICPR (T.V., Radio, etc.)?_____

In case of an emergency contact phone_____Relationship/Name_____

Nearest friend or relative not living with you _____Phone_____

Pharmacy of choice _____

INSURANCE INFORMATION:

Insured Name _____SS# _____
Last First M

Insured Date of Birth _____ Relationship to Patient _____

Address of Insured if different from patient _____

Insured's Employer _____Phone _____

Insurance Co _____ Policy # _____Group#_____

Address _____ City _____State_____ Zip_____

SECONDARY INSURANCE INFORMATION:

Insured Name _____SS# _____
Last First M

Insured Date of Birth _____ Relationship to Patient _____

Address of Insured if different from patient _____

Insured's Employer _____Phone _____

Insurance Co _____ Policy # _____Group#_____

Address _____ City _____State_____ Zip_____

GUARANTOR OF ACCOUNT (IF DIFFERENT FROM THE INSURED):

Guarantor Name _____ SS# _____
Last First M

Address_____ City _____State _____ Zip_____

Phone Number _____Date of Birth _____Martial Status_____

ICPR POLICIES:

Payment Arrangements: Payment for services rendered is due at the time of service. Co-pays and deductibles will be collected at each visit as they apply. We will be happy to submit to your insurance company on your behalf. You must sign an assignment of benefits below notifying your insurance company that you have given permission to them to send payment directly to ICPR. If you do not wish to sign, you will be responsible for the entire amount of the visit at the time services are rendered. Any billable balances are due immediately upon receiving the statement from ICPR. You must come in to the billing department for any payment arrangement needs and we will assist you with the application process with Personal Finance Company. A realistic and appropriate arrangement can be made through PFC. For your convenience we accept, Visa, MasterCard, Discover, AMEX, direct deduction, personal checks and cash. We are no longer accepting new patients with the medical card. If your status changes to the medical card within 6 months of becoming our patient we reserve the right to terminate the relationship. Please note that non-payment of an account will also lead to collection action and termination as a patient of ICPR.

Medicare Patients: Our office participates in the Medicare program and accepts the amount Medicare approves for covered services. If you are a Medicare beneficiary, we ask that you pay for non-covered services and deductible's at the time of service. If you have a supplemental insurance that covers your Medicare deductible and co-payments, we will submit a claim to that carrier for you.

Medicaid Patients: If you are an Illinois Department of Public Aid recipient you must present your medical card each time you visit our office. Unless it is an emergency, you will not be seen without your card. It is a requirement of IDPA HHS, to have a selected PCP; if our office is not designated as your medical home, you will need to reschedule your appointment until the appropriate change has been made. Your $2.00 co-pay will be collected at each office visit.

Work Comp, Motor Vehicle & Personal Injury: The patient will need to fill out the appropriate paperwork before being seen. The patient will have to present proof of coverage for each visit. In the event proof is not available the patient will be responsible for that days visit at the time of service. The patient will be responsible for any remaining amount due on account after payment is made by a 3rd party liability, any services denied for payment for any reason by the 3rd party liability, or if payment is not made within 60 days from file date. If you are in need of a payment arrangement, please see the billing department.

Custodial Parents: For legal purposes, we can only bill the custodial parent for a child's medical fees. If another party wishes to assume financial responsibility for medical services provided by our office, he/she will have to sign a form in person at our office.

Appointments: Arriving late for an appointment will cause the patients scheduled after you to have to wait unnecessarily. You may be asked to reschedule an appointment if you arrive more than 10 minutes late for a scheduled appointment. We require a 24 hour cancellation notice on any appointment. A fee of $20.00 will be added to the patient's account for all appointments not cancelled. ICPR reserves the right to dismiss the patient from the practice if they no show for 3 or more appointments within one year. A healthcare provider may be late in seeing you for an appointment. Unfortunately, unexpected emergencies or complications may occur with the previous patient causing us to run behind. We promise to do everything in our power to stay on time and give you the same careful attention during your visit with us.

Notice of Privacy Practices: I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Medication Refills: If you are in need of a medication refill, please call your pharmacy. Your pharmacist will fax a request to our office and we will then fax the request back to the pharmacy. Please be aware that we request 24 hours notice on all medication refills. ICPR follows strict guidelines when prescribing controlled substances. A Substance Agreement must be signed by each patient that has a controlled drug prescribed for them. Failure to comply with the terms of the agreement will result in Immediate termination from the practice.

I, the undersigned, certify that the information I have given is true and accurate to the best of my knowledge. I also certify that I (or my dependent) have insurance coverage with the above company whether commercial or governmental, and I assign all benefits to be paid directly to ILLINOIS CENTERS FOR PAIN AND REHAB. I authorize ICPR to release any and all information needed to secure payment of benefits. I authorize the use of this signature to use on all insurance submissions. I also understand that by signing below I agree to be financially responsible for any balance on the above said account. I also understand that in the event that my account becomes past due it will be turned over to a collection agency and I will be terminated from ICPR. I agree to pay all costs of collection. Collection costs include court costs, reasonable attorney fees and collection agency commissions or charges. A collection agency commission is typically 33 1/3 % of unpaid balance up to 50%. I agree to release any information in order for the collection agency to reach me.

_____ _____
Patient Signature (Guardian if Patient is a minor) Date