Volkan Sumer, DO
Tonya Dennison, FNP-C
Shauna Bivens, FNP-BC
Katie Rollyson, FNP-BC
Cody Beer, FNP-C
Kristin Ross, PT

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

Notice of Privacy Practices Acknowledgement
ICPR Family Practice

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

I wish to have the following restriction on disclosure of health information: ________________
____
____.

____
Initials

I authorize the physicians and staff of ICPR Family Practice to release of information about my medical condition to the following person(s).

Name: ___________________________Ph#______________Relationship: _________________
Name: ___________________________Ph#______________Relationship: _________________
Name: ___________________________Ph#______________Relationship: _________________

____
Initials

☐ I authorize a representative of ICPR to leave a message regarding upcoming appointments on the answering machine at my home.

☐ I agree to have appointment reminders e-mailed to the following address:

____

____
Initials

Signed: ____ Date ______________________

Relationship (*If not signed by patient*) ____

ICPR Witness: ____