Orland Primary Care Specialists

16660 S. 107th Ave., Orland Park, IL 60467
708/403-8500 Fax 708/364-7080

Pediatric Patient Registration Form

PATIENT INFORMATION (Please use full legal name, no nicknames)

Last Name:_____ **First Name:**_____ **Middle Initial:**_____

Date of Birth:_____ **Age:**_____ **Home Telephone #:**_____ ☐ Male ☐ Female

Home Address:_____

City:_____ **State:**_____ **Zip Code:**_____

☐ Child Resides with Both Parents ☐ Child Resides with ☐ Mother ☐ Father ☐ Child Resides with Legal Guardian

(Please list name(s) of parents or legal guardian(s) and circle their releationships)

Name of Parent(s) or Legal Guardian(s): _____ _____
Father or Guardian Mother or Guardian

Social Security #s Parent(s) or Legal Guardian(s): _____ _____
Father or Guardian Mother or Guardian

Cell Phone # of Parent(s) or Legal Guardian(s):_____ _____
Father or Guardian Mother or Guardian

Work Phone # of Parent(s) or Legal Guardian(s):_____ _____
Father or Guardian Mother or Guardian

Email Address of Parent or Legal Guardian:_____
(Please list one email address and name of the parent or guardian who's address is listed)

Emergency Contact Name:_____ **Relationship:**_____

Emergency Contact Telephone #:_____

INSURANCE INFORMATION (Please present your insurance card(s) and photo ID to the receptionist for scanning)

PRIMARY INSURANCE ☐ Employee Group Policy ☐ Private Policy

Plan Name:_____ **Policy Holder's Name**_____

Policy Holder's Address ☐ same as patient Or _____
(Address, City, State, & Zip code if different from patient)

Policy Holder's Date of Birth:_____ **Policy Holder's Relationship to the patient:**_____

Policy ID #:_____ **Group #:**_____ **Effective Date of Policy:**_____

SECONDARY INSURANCE ☐ Employee Group Policy ☐ Private Policy

Plan Name:_____ **Policy Holder's Name**_____

Policy Holder's Address ☐ same as patient Or _____
(Address, City, State, & Zip code if different from patient)

Policy Holder's Date of Birth:_____ **Policy Holder's Relationship to the patient:**_____

Policy ID #:_____ **Group #:**_____ **Effective Date of Policy:**_____

PLEASE CONTINUE FILLING OUT REGISTRATION FORM ON BACK SIDE

PRIMARY CARE PHYSICIAN INFORMATION:

Primary Care Physician (If applicable to your insurance plan - HMO, Point of Service, or Illinois Health Connect)

Primary Insurance: ☐ **Ananya Spann, MD** ☐ **Kevin Germino, MD** ☐ **Martin Borenstein, MD**

Secondary Insurance: ☐ **Ananya Spann, MD** ☐ **Kevin Germino, MD** ☐ **Martin Borenstein, MD**

EMPLOYER INFORMATION: (Parents or Guardians)

Employer Name:_____

Employer Address:_____

Employer Telephone #:_____ **Parent/Guardian Name:**_____

****

Employer Name:_____

Employer Address:_____

Employer Telephone #:_____ **Parent/Guardian Name:**_____

RACE, ETHNICITY, LANGUAGE, & REFERRAL SOURCE:

Ethnicity: ☐ **Non-Hispanic** ☐ **Hispanic** ☐ **Refused to Report**

Primary Race: ☐ **White** ☐ **Hispanic** ☐ **African American or Black** ☐ **Asian** ☐ **American Indian or Alaska Native**
☐ **Native Hawaiian or Other Pacific Islander** ☐ **Other Pacific Islander** ☐ **Other Race**
☐ **Unreported– Refused to Report**

Language Spoken: ☐ **English** ☐ **Spanish** ☐ **Other** _____

What is the birth order of the patient? _____ **(Please list by number, with oldest child starting as number 1)**

How or by whom were you referred by to our practice:_____

ELECTRONIC PRESCRIPTIONS:

Our electronic medical record program accesses your prescription/medication history in order for us to safely prescribe your medication. By signing this, you give authorization to Orland Primary Care Specialists to access your child's medication history.

Signature of Parent or Legal Guardian:_____ **Date:**_____

I authorize the release of any medical information necessary to process my insurance claims. I authorize payment of medical benefits to Orland Primary Care Specialists and further understand I am financially responsible to Orland Primary Care Specialists for any copayments, deductible, coinsurance, or services not covered under my insurance. I understand that it is my responsibility to know my insurance benefits and whether or not the services my dependents receive are a covered benefit. I acknowledge the above listed information I have provided to be true and correct.

_____ _____ _____
Signature of Parent or Guardian **Relationship to Child** **Date**

_____
(Please print name of parent or guardian who signed above)

Orland Primary Care Specialists

16660 S. 107th Ave., Orland Park, IL 60467
708/403-8500 Fax 708/364-7080

Patient Privacy Directive

PATIENT INFORMATION

Last Name:_____ **First Name:**_____ **Middle Initial:**_____

Date of Birth:_____ **Home Telephone #:**_____

Address:_____

Parent/Guardian Name (if Patient is a Minor) :_____ **Relationship to Patient:**_____

Please provide our office with the phone numbers(s) we or an automated service may leave messages regarding your appointments, medical care, and billing information or requests:

_____ _____

Please provide our office with the name(s) and their relationship to your or your dependent(s) in which you authorize our office to give or communicate information regarding your appointments, medical care, and billing information or requests:

_____ _____
Name of authorized person **Relationship to the patient**

_____ _____
Name of authorized person **Relationship to the patient**

_____ _____
Name of authorized person **Relationship to the patient**

_____ _____
Name of authorized person **Relationship to the patient**

Please provide our office with an email address we may communicate your health information to you:

_____

Please be aware, your must inform Orland Primary Care Specialists in writing of any changes to your directives.

I acknowledge the above listed information I have provided to be true and correct.

_____ _____ _____
Signature of Patient or Guardian **Printed Name of Patient or Guardian** **Date**

As a patient of Orland Primary Care Specialists, Inc., I have been provided with its Notice of Privacy Practices, which describes how medical Information about me may be used or disclosed, and informs me of my individual privacy rights.

I acknowledge I have received the Notice of Privacy Practices and I understand how medical information about me may be used, the duties of Orland Primary Care Specialists, Inc., and my rights to privacy protection and access to my medical information. I understand the Office Administrator of Orland Primary Care Specialists, Inc. is available to answer any questions that I may have regarding issues of privacy.

_____ _____ _____
Signature of Patient or Guardian **Printed Name of Patient or Guardian** **Date**

Orland Primary Care Specialists

16660 S. 107th Ave., Orland Park, IL 60467
708/403-8500 Fax 708/364-7080

Orland Primary Care Specialists
Financial Policy

In order for Orland Primary Care Specialists to provide our patients with the highest quality of care possible, and afford our patients the convenience and cost efficiency of medical care management within our office, we find it necessary to provide a financial policy. ***Please read all information and acknowledge by signing below.***

1. **Please present your current insurance card(s) at each visit.** Failure to do so, may make you liable for any denied claims. If you have any type of coverage through the Illinois Department of Health and Family Services Programs, you must present a current eligibility card in order for OPCS to bill the State of Illinois. If we do not have the current information, you will be responsible for payment. If the patient is on an Illinois State Insurance Program where a primary care physician must be elected, the patient must be assigned to one of the physicians within Orland Primary Care Specialists in order for us to bill your services to the State of Illinois. If the patient is not listed under a physician within our practice, it will be the patient's responsibility for payment of services.

2. **We will ask you for a current state photo ID at your initial visit.** If the patient is under the age of 18, we will ask the parent or legal guardian for a current state photo ID. If you are an established patient, and we do not have a photo ID on file, or if you are transferring from our Pediatric Department to the Internal Medicine Department, we will ask for a photo ID. Please be aware, if you are a new patient and do not have a photo ID, your appointment may be rescheduled to another day when you are able to present your photo ID.

3. **If you have a copay under your insurance plan,** this will be collected at the time of check in. We do not bill for copayments unless there are unusual circumstances or prior to your appointment special arrangements have been made with our billing department. We do not send statements for any balances under $5, but will request payment be made at the time of your next visit. We may ask that you make payment, at the time of service, on any services which are not covered under your insurance plan. We accept cash, checks, Visa, MasterCard, American Express, and Discover.

4. **If we do not participate with your insurance,** we will file your claims as a courtesy and ask that <u>*you*</u> follow-up to make sure payment is made to us in a timely manner. Once your insurance carrier has made reimbursement for services rendered, any remaining balance is payable by you in full within 30 days. We understand circumstances may arise where payment can not be made in full, and ask if you can not pay your balance in full, to contact our Billing Office to set up special payment arrangements. If at any time there is a problem with payment arrangements, please contact our Billing Office.

5. **Filing Claims to your insurance company:** Please be aware our Billing Department reviews all services before they are submitted to your insurance carrier. This is done in order to confirm all services are billed at a correct level of service based on the physician's documentation. We also review documentation to confirm the proper type of service. There are two types of service a physician will most frequently bill for, the ***"Office Visit"*** for diagnostic purposes or a ***"Physical"*** for preventive health care. When you see your physician for an Office Visit, it is for the purpose of discussing new or existing problems. When you see your physician for a Physical, it is for the purpose of a thorough review of your general well being. These services can only be filed to your insurance carrier based on the physician's documentation, ***your medical record is a legal record, and cannot be manipulated to bill based on the patient's health insurance benefit***. To do so would be fraudulent. Please note: If both services are provided, this office reserves the right to bill for both the office visit and physical as provided to the patient.

6. **Liability Related Services:** Please be aware if you are seeing your physician for injuries sustained in an automobile accident or any type of injury where your services are not filed through your health insurance carrier, you will be financially responsible for payment within 30 days from the date of service. We will file a claim to the liability carrier as a courtesy, but will not wait for reimbursement past 30 days or be involved in any delay in payment due to litigation.

Orland Primary Care Specialists
Financial Policy (continued)

7. **Self Pay Patients:** Patients without insurance coverage will be expected to pay at time of service. For all self pay patients, we discount our fees to a self pay rate. If you are unable to pay your services in full, at the time of service, you must contact our Billing Department prior to seeing your doctor.

8. **Service Fee for returned checks:** If your check is returned from the bank as "Non-Sufficient Funds", "Account Closed", or any other reason, Orland Primary Care Specialists will apply a finance charge of $25 to your account.

9. **No Show or Missed Appointments:** We understand there may be times when your are unable to keep an appointment. We ask that you please contact our office if you are unable to come in for your scheduled appointment. If we are not contacted for two missed appointments within a six month period or by two appointments missed by family, a letter will be sent to you explaining if another appointment is missed with out a call to cancel or reschedule, you will be responsible for a $35 fee for "Missed Appointments".

10. **To the parents or guardians of our pediatric patients:** Please be aware, we do not get involved in separations or divorce. The office policy as directed by our legal counsel is as follows: The parent or guardian who brings the child in to our office for medical care, is the person who is financially responsible for any payment due. It is up to this person to go back to the court system and collect any reimbursement due to them. Please be aware if there have been any changes to release of information on your child, and this differs from the original release forms given to Orland Primary Care Specialists, we will ask that your provide documentation from the court, to support this request.

11. **If Collec*tion Action* through our *Collection Agency* is required to collect payment due by you for services rendered, the following will occur:** The 25% processing fee our collection agency requires OPCS to pay for the collection of your debt will be added to your balance and payable to Orland Primary Care Specialists. If you account is turned for collection, and you return to our office for services, you will be required to pay for any new services at the time of service at a self pay rate. We will file to your insurance carrier for services rendered, apply any contractual adjustments and/or insurance payments to your account. If there is a credit on your account following your insurance company's reimbursement, a refund check will be requested and mailed to the insured. This policy of payment at the time of service will remain for two years for the patient and/or family members who are of financial responsibility of the guarantor involved.

12. **Record Copy Requests** A $10 fee is required for any record copy requests made by our patients for reasons of transferring to another physician or for a patient's own personal record. If you or your family are moving out of state, records will be sent directly to the physician's office you request at no fee. If records are requested by a specialist, we will contact the specialists office and ask what records are necessary for his or her review, and those records will be sent to his or her office at no fee. If you are bringing past medical records in to our office from another physician's office or are having your past medical records sent to our office from a previous physician, we will scan those records into your electronic medical record, and then contact you to pick those records up. Please be aware, if you later want your records transferred or are requesting a personal copy of your record, it will not include the previous physician's records. Any other record requests as requested by an attorney's office or insurance carrier, will be subject to the state rate for record copying.

Please remember, whether you have insurance or not, you are ultimately responsible for payment of your services and/or your dependent's services in full. If you have any questions regarding our financial policy, please contact our billing department or practice administrator.

I have read and acknowledge the above financial policy of Orland Primary Care Specialists

_____ _____

Signature of Patient or Guardian **Date**

_____

(Printed name of signature of patient or guardian as listed above)