Advanced Medical Consultations

ADVANCED MEDICAL CONSULTATIONS, LTD
Tel: 630 366 6681, Fax: 630 366 6550
Web: www.mconsultations.com
715 W. Lake Street, Suite 104, Addison, IL, 60101

NEW PATIENT REGISTRATION FORM

CONTACT INFORMATION

Last Name:	First Name:	
Date of Birth: / /	Age:	Social Security Number: - -
Sex: Male Female	Marital Status: Single Married Divorced Separated Widowed	
Phone Number: ( ) -	Alternate Phone Number: ( ) -	
Address:	City:	Zip:
Email:		
Identified Representative Name:	Phone Number:( ) -	
Identified Representative Email:		
Identified Representative Relationship to Patient: Power of Attorney for Health Care *Durable* Power of Attorney For Health Care Legal Guardian Caregiver Relative: Other:		
Alternate/Emergency Contact Name:	Phone Number:( ) -	
Primary Insurance:	Contract #:	
	Relationship to Patient:	
Secondary Insurance:	Contract #:	
	Relationship to Patient:	
Primary Pharmacy:	Phone Number:( ) -	
Mail Order Pharmacy:	Phone Number:( ) -	
Referral Source:		

Preferred Language: English Other: _____

Ethnicity: Hispanic or Latino Origin Not of Hispanic or Latino Origin Decline to state

Race: ☐ American Indian or Alaskan Native Asian Black or African American White
☐ Native Hawaiian Other Pacific Islander More than one race Decline to state

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GENERAL CONSENT TO TREATMENT

I hereby voluntarily consent to the performance of such diagnostic procedures and/or medical treatment as my physician, non-physician practitioner (PA-C/CNP), their assistants or designees at Advanced Medical Consultations, LTD may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, specialty referrals, and routine medical care. I authorize my physician(s) or provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my care is directed by my physician/provider and that other personnel render care and services to me according to the physician's instructions.

- I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me with regard to results of such diagnostic procedures or medical treatment.
- I understand that samples of body fluids and/or tissues may be withdrawn from me during routine diagnostic procedures, and authorize Advanced Medical Consultations, LTD to properly dispose of these body fluids.
- I have been informed and understand that an HIV (Human Immunodeficiency Virus- AIDS) test may be performed on me without my consent if a health professional or Advanced Medical Consultations, LTD employee sustains an exposure to my blood or other body fluid.

I acknowledge that I have read or have had read to me this consent, and fully understand its details. I have had the opportunity to ask questions, and have had these questions addressed.

Patient Signature: _____ **Date:**_____

Patient Name: _____ **Date of Birth:** _____

If patient is unable to sign:

- ○ Consent of Legal Guardian, Power of Attorney for Health Care, or Patient
- ○ Advocate Consent of Caregiver or Nearest Relative

Name: _____ Relationship: _____

Telephone: _____ Address: _____

Signature: _____ Date: _____

CONSENT TO CONTACT

I would like to be contacted with information regarding my treatment using the following methods: Please mark the appropriate boxes and check all that apply:

☐ Home Phone ☐ Cell Phone ☐ Home Address ☐ Work Phone ☐ Text Message
☐ Email:

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ASSIGNMENT OF BENEFITS

Subscriber's Name: _____ Relationship to Patient: _____

Patient Name: Date of Birth:
Medicare Number: _____ Social Security Number:

Other/Secondary Insurance: _____

Policy Number: _____ Group Number: __

I hereby assign and request that payment of authorized insurance benefits, including Medicare if applicable, be made on my behalf to Advanced Medical Consultations, LTD for any medical services provided.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to Advanced Medical Consultations, LTD, the Centers for Medicare and Medicaid Services, any other insurance carrier with whom I have coverage.

I understand that I am financially responsible to Advanced Medical Consultations, LTD for any charges not covered by health care benefits, and I am only responsible for any deductible, co-pay or other amounts for services not covered by my insurance. I understand that Advanced Medical Consultations, LTD agrees to accept the payment made by Medicare and any other insurance coverage as its full charge. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. It is my responsibility to notify Advanced Medical Consultations, LTD of any changes in my health care coverage. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services received.

I acknowledge that I have read or have had read to me this assignment of benefits, and fully understand its details. I have had the opportunity to ask questions, and have had these questions addressed.

Patient Signature: _____Date:____

If patient is unable to sign:

Responsible Party: _____ Relationship:

Telephone: _____ Address: _____

Signature: _____ Date:

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name:_____ Date of Birth:

Social Security: _____ Maiden / Other Names: _____

Patient Address: _____

Patient Phone Number(s):

I authorize _____ to release health information that identifies me (including if applicable, information about HIV/AIDS treatment or testing, information about substance abuse treatment, and information about mental health services). **PLEASE CROSS OFF ANY THAT SHOULD NOT BE RELEASED.**

Person or organization to whom the information may be released:

NAME PHONE

ADDRESS FAX

Specify the type of information to be disclosed:

❑ Discharge Summary ❑ History & Physical ❑ Consultations ❑ Laboratory Results

❑ X-Ray Report(s) ❑ X-Ray Film(s) ❑ Operative Report(s) ❑ Pathology Report(s)

❑ Other (specify): _____

Date(s) of Treatment: _____

The purpose and need for such disclosure:

❑ Continuation of Care/ Transfer of Care ❑ Insurance Investigation ❑ Social Service Referral ❑ Attorney/Legal

❑ Vocational Rehabilitation ❑ Billing Information ❑ Disability Determination ❑ Workman's Compensation

❑ Other (specify): _____

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I understand that:

- This authorization is voluntary, and that treatment or payment will not be conditioned based on this authorization or revocation unless otherwise allowed by law.
- My health information will be disclosed as specified in this authorization. If I do not sign this authorization, Advanced Medical Consultations, LTD will not disclose my health information as requested, except as required by law.
- This authorization is valid for one year from the date signed, unless I revoke this authorization, or unless an earlier date is specified here: _____ . I may revoke this authorization by sending a written request to Advanced Medical Consultations, LTD by mail or fax. Once my health information is disclosed as requested, it is subject to re-disclosure by the recipient and may no longer be protected.

Patient Signature: _____ **Date:**

If patient is unable to sign:

Responsible Party: _____ Relationship: ____

Telephone: _____ Address: _____

Signature: _____ Date:

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

My signature below is an acknowledgement that I have read, or have been read, and have received a written copy of the Advanced Medical Consultations, LTD Notice of Privacy Practices and Individual Rights.

PATIENT NAME (Print) **DATE OF BIRTH**

PATIENT SIGNATURE **DATE**

[OR **]**

IF PATIENT IS UNABLE TO SIGN:

☐ Received by Legal Guardian, Power of Attorney for Health Care, or Patient Advocate

☐ Received by Caregiver or Nearest Relative

NAME (Print) **RELATIONSHIP TO PATIENT**

TELEPHONE **ADDRESS**

SIGNATURE **DATE**

FOR ADMINISTRATIVE USE ONLY:
Advanced Medical Consultations, LTD has made a good faith effort to obtain the above referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices and Individual Patient Rights.

Acknowledgement could not be obtained for the following reason(s):
___ Patient/Individual refused to sign (Date of refusal: _____)
___ Communication barriers prohibited obtaining acknowledgement
___ An emergency situation prevented us from obtaining acknowledgement
___ Other: _____

Attempt made by: _____ Date attempt made:

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NOTICE OF PRIVACY PRACTICES AND INDIVIDUAL RIGHTS

DISCLOSURES AND USES OF YOUR HEALTH INFORMATION

Each time that you visit a hospital, a physician, or another health care provider, a record of your encounter is made. Typically, this record contains your health history, current symptoms, examination, test results, diagnoses, treatment, and plan for future care or treatment. This information, linked with your name or other identifying information, is used in many ways such as providing care, obtaining payment for your care, and running our business.

As permitted by HIPAA Advanced Medical Consultations, LTD may use or disclose your health information for several purposes as listed below. Disclosures of your medical information for purposes described in this notice may be made in writing, orally, electronically, or by facsimile. Except as listed below, we will not use or disclose your health information without your authorization.

To Provide Treatment: Advanced Medical Consultations, LTD may use or disclose your health information to provide you with medical care in your home. We also may share your health information with others who provide care to you, such as hospitals, doctors, nurses, physician assistants, therapists, technicians, emergency service and transport providers, medical equipment providers, pharmacies, and others involved in your care.

***To Provide Payment*:** Advanced Medical Consultations, LTD may use or disclose your health information as needed to obtain payment from your insurance providers for services that we provide to you.

***To Conduct Healthcare Operations*:** Advanced Medical Consultations, LTD may use or disclose your health information in connection with our healthcare operations and as needed to run our office. These operations may include quality assessment and improvement activities, certification, licensing, credentialing, accreditation, training programs, compliance, auditing, evaluating practitioner and provider performance, and reviewing the competence or qualification of health care professionals.

Appointments: Advanced Medical Consultations, LTD may use your health information to contact you regarding upcoming appointments, or to obtain additional demographic or contact information, through phone calls, voicemail messages, postcards, or letters.

To Business Associates: Advanced Medical Consultations, LTD provides and receives some services through contracts with business associates. When we use these services, we may disclose your health information to the business associates so that they can perform the function(s) that we have contracted with them to do and bill you or your third-party payer for services provided. To protect your health information, however, we require the business associates to appropriately safeguard your information.

To Persons Involved with Your Care or Payment for Care: Advanced Medical Consultations, LTD may use or disclose health information to assist in the notification of a family member/personal representative regarding your general condition, treatment plan, or death. If you are present, prior to use or disclosure of your health information, we will provide you with the opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information about you based on a determination using our professional judgment disclosing only pertinent health information directly relevant to the person's involvement in your healthcare. With your consent, we may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment information.

As Required By Law: Advanced Medical Consultations, LTD may use or disclose your health information as required by any statute, regulation, court order, or other mandate enforceable in a court of law.

Abuse or Neglect: Advanced Medical Consultations, LTD may disclose your health information to the appropriate government agency if we reasonably suspect that you are a victim of abuse, neglect, domestic violence, or other crime and we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless it is determined that doing so would not be in your best interest. We may also use or disclose your health information to the extent necessary to avert a serious threat to your health or safety or to the health or safety of others.

Public Health: As required by law, Advanced Medical Consultations, LTD may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

National Security: Advanced Medical Consultations, LTD may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal personnel health information required by lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances.

Worker's Compensation Purposes: Advanced Medical Consultations, LTD may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Judicial and Administrative Proceedings: Advanced Medical Consultations, LTD may disclose your health information in an administrative or judicial proceeding in response to a subpoena or request to produce documents. We will disclose your health information only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Health Oversight Activities: If employees of Advanced Medical Consultations, LTD or our business associates believe in good faith that we have engaged in unlawful conduct or otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public, we may disclose your health information to health oversight agencies and/or public health authorities such as the Department of Health.

To the U.S. Department of Health and Human Services (DHHS): Under the privacy standards, Advanced Medical Consultations, LTD may disclose your health information to DHHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

Research: Advanced Medical Consultations, LTD may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. “Research” refers to systemic investigation designed to contribute to generalized knowledge.

In Connection with your Death or Organ Donation: Advanced Medical Consultations, LTD may disclose your health information to a coroner for identification purposes, to funeral directors for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs, consistent with applicable federal and state law to enable them to carry out their duties.

Incidental Uses and Disclosures: Advanced Medical Consultations, LTD may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this notice.

Patient Authorization to Use or Disclose Health Information: In addition to using your health information for treatment, payment and healthcare operations, you may give Advanced Medical Consultations, LTD written authorization to use your health information or disclose it to anyone for any purpose. If you give us written authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted during the time your authorization was in effect. If you do not give us written authorization, we cannot use or disclose your health information for any reason *except those described in this notice*.

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CHANGES TO OUR NOTICE OF PRIVACY PRACTICES

Advanced Medical Consultations, LTD reserves the right to change our privacy practices and terms of this notice at any time as long as law permits it. We reserve the right to develop new terms of notification procedures in order to maintain alignment with legal and governmental requirements. Updates to this notice and new notices will be available as changes to our privacy practices occur.