ADVANCED HEART GROUP, S.C.
71 WEST 156TH STREET · SUITE 305
HARVEY, ILLINOIS 60426
TELEPHONE: (708) 331-2200

New Patient Intake Form

Personal Information:

Name: _____

Date of Birth: _____

Last Four Digits of Social Security: _____

Address: _____

City/State: _____ Zip: _____

Phone: _____

Secondary Phone: _____

Email: _____

Preferred Contact Method: Phone E-Mail Mail

Date of Birth: _____

Gender: Female Male

Marital Status: ●Single •Married ●Widowed •Divorced

Emergency Contact/Relationship: _____Phone: _____

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Decline to answer

Race:

American Indian or Alaksa Native

Asian

Black or African American

Native Hawaiian or Other Pacific Islander

White

Other

Decline to answer

Insurance Information:

Please Provide the office with your Insurance Card(s) and Photo ID

Policy Holder's Name: _____ Relationship to Policy Holder: _____

Primary Insurance Company: _____

Policy#: _____

Group #: _____

Secondary Insurance: _____

Policy#: _____

Group#: _____

Pharmacy Information:

Name of Current Pharmacy: _____ Phone Number: _____

Location (City/Cross Street):

_____

Additional Information:

Primary Care Physician Name: _____

Phone: _____

How were you referred to our office?

_____

Name & Phone number of Employer:

_____

Is this visit work related (injured at work/workmen's comp. claim)? Yes No

Patient Disclosure Agreement and Responsibilities

Patient's Name: _____ Date of Birth: _____

I agree that I will be expected to pay $25.00 for any missed appointments if I fail to notify the office 24 hours in advance. I will have to reschedule any appointment if I am unreasonably late.

I will make every effort to understand the benefits of my insurance plan, even to the extent of calling the carrier or speaking with a benefits coordinator at the place of my employment. I understand that the insurance company may not release this information to the practice. I am responsible for obtaining all necessary referrals from my Primary Care Physician. I am ultimately responsible for payment services I receive, including services not covered by my insurance plan. **I am responsible for my Co-Pay at the time of check-in for any appointment.**

I agree to pay $50.00 as a charge for any check that is returned by my bank for Non-Sufficient Funds (NSF) or denial of payment, in addition to the actual amount of the check written, payable cash. This is to cover the penalty that is charged to the practice by the bank.

If I fail to pay my bill in a satisfactory manner after a reasonable time and my account is assigned to a collection agency or attorney, I agree to pay the costs of collection, including but not limited to attorney fees and court fees.

I understand this is the policy of Advanced Heart Group, S.C. and agree to be bound by the obligations and secured by the rights set for herein.

Patient Signature: _____

Date of Signature: _____

Office Payment Policy

Changes consequent to the Affordable Care Act (ACA) have resulted in adjustments necessary for your office visit payments. We are committed to providing you with the highest quality of care and have implemented the following office policies:

Payment is due at the time of check-in for all medical services without exception. If you have Medicare and a Medicaid low deductible "Plan F" supplement, your insurance should cover all charges including deductibles and coinsurances and in this specific case payment will not be expected at your time of check-in. This is the only insurance combination that no payment is necessary at the time of service.

If you are insured by any other plan:

You will be required to pay in full any co-pay amount of outstanding balance at the time of your visit. Any balances not paid by your insurance will be your responsibility. All balances, with the exception of co-pays, are due once we have received notification from the carrier.

Patient Responsibilities:

1. You are responsible for knowing your insurance coverage.

2. We are required by law and by our contractual obligations with insurance carriers to make every attempt to collect patient co-payments and deductibles for insurance plans. We stand at risk of being accused of "over-utilization" if we waive any co-pays, even for "professional courtesy". We are therefore unable to waive co-payments.

3. Insurances: We participate with most insurance plans, including Medicare. If you are not insured by a plan that we are contracted with, payment in full is expected at each visit. If you are insured by a plan that we do business with but do not have your up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Please contact your insurance company with any questions regarding coverage.
4. Non-covered services: Please be aware that some and sometimes all the services you receive may be non-covered or not considered reasonable or necessary by insurance carriers. You must pay for these services in full at the time of your visit.

5. Proof of insurance: All patients must complete their new patient form before seeing any doctors. We must obtain a copy of your Driver's License and current Insurance Card(s). Failure to provide correct insurance information may result in the patient being responsible for payment.

6. Claims Submission: Our office will submit your claims and assist you in any way we reasonably can to help get your insurance claims paid. Your insurance benefits are a contract between you and your insurance company, we are not a part of that contract. Therefore, payments for services are the patient's responsibility.

7. Coverage Changes: If your insurance changes please notify us right away, so that we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to the patient.

8. Nonpayment: If your account is over 90 days past due, partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection party.

9. Missed Appointments: Our policy is to charge $25.00 for missed appointments that are not cancelled or informed to us at least 24 hours before the scheduled appointment. These charges will be your responsibility and billed directly to you and not your insurance company. If you are here but were not able to see the physician for any reason, then there will be no charge.

*Please be aware that any calls regarding your amount due at the time of service are an estimate only. Once your insurance receives the claim they will determine the final patient responsibility per your benefit plan. *

I have read and understand that I am personally responsible to pay in full for services that my health insurer will not cover, including those services not covered due to non-payment of my health insurance premiums.

Patient Name: _____

Patient Signature: _____

Date: _____

Consent for Release and Use of Confidential Information and Receipt of Privacy Practices Form

I, _____ hereby give my consent to Advanced Heart Group, S.C. to use or disclose, for the purpose of carrying out treatment, payment or health care operations, all information contained in the patient record of

_____(Patient's Name)

I acknowledge receipt of the Physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose confidential information.

I understand that the Physician has reserved a right to change his or her Privacy Practice that are described in the Notice., I also understand that a copy of any Revised Notice will be provided to me or made available.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so. I also understand that I will not be able to revoke this consent in cases there the Physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the Physician's office.

Patient Signature: _____

Date: _____

If you are not the patient, please specify your relationship to the patient:

_____