Welcome to Our Office

Aurora Internal Medicine Clinic, PC

Patient Name: (This section refers to the patient only)

Name:_____ Age_____ Date of Birth_____

Address:_____ City_____ State_____ Zip_____

Home Phone:_____ Mobile Phone:_____

Spouse or alternative contact information:_____

Sex:_____ Social Security #:_____ Email:_____

Employer:_____ Work Phone:_____

Name and # of Local Pharmacy:_____

Name of Mail-in Pharmacy:_____

Please give the receptionist your insurance card and ID so we can make a copy

Emergency Notification: (not living with you)

Name:_____ Relationship:_____ Phone:_____

Consent for test results:

I give Aurora Internal Medicine Clinic, PC, permission to leave all x-ray, appointments, lab results, test results and other medical information and advice on: (check all that apply).

□ mobile phone □ voice mail home/work □ Immediate family member

□ other_____

I hereby acknowledge that I have received a copy of Aurora Internal Medicine Clinic's notice of privacy practices. I authorize the release of any medical information and payment of medical benefits to the physicians or supplier for services necessary to process a claim. I agree to be responsible for any deductible, co-insurance, co-pay or any other balance not paid by my insurance.

Patient Name:_____ Date:_____

Signature:_____ Relationship to Patient: □ self □ parent □ guardian

Payment Policy:

I understand that I am responsible for all charges incurred by me regardless of insurance coverage and that PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. We are unable to submit claims to insurance companies unless we are contracted with them. However, payment can be made by check, MC/VISA, or cash. There will be a $20 charge on all returned checks. A $15 service charge will be accessed if the co-pay is not paid at the time of service. Any unpaid patient balance over 60 days will be assessed a $20/month fee until paid in full unless otherwise discussed with the Office manager. Information will be given to you so that you may bill your insurance company for the reimbursement. In the event that yor bill is turned over to a collection agency, collection fees, attorney fees, and court costs will be added to your account balance and you and your family. Members will be dismissed from the practice.

Financial Policy:

We are committed to providing you with the best possible care, and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. We must emphasize that as health care providers, our relationship is with you, not your insurance company. Your insurance is a contract between you, your employer, and the insurance company.

Cancellations:

Patients who fail to arrive on time for their appointments without giving 24hours notice may be charged $30-$50 for the time allotted for their appointment. Please give as much notice as possible if it is necessary to cancel an appointment. This will not be covered by insurance.

Medical Records:

Please note that at any medical records sent or brought into our office for your personal file become the property of Aurora Internal Medicine Clinic, PC., and will not be copied or returned once reviewed. When transferring records from our office, there will be a copying fee. No records can be transferred without a signed release.

Notice of Acknowledgement of Privacy Policy and Procedures:

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), AIMC, PC, may not use or disclose your personal health information without your authorization. This practice has policies and procedures to comply with HIPAA law. Every attempt has been made to keep the process for a patients and staff as efficient as possible. However, the requirements are extensive, take time, effort, and cooperation to process the required tasks. All patients are presented with certain notices and must sign certain forms. Depending on the course of treatment, some patients may be required to sign additional consent forms. A list of available forms is posted and available upon request.

Insurance Release: (Signature and date required on all four lines)

Patient or authorized person signature:

I authorize the release of any medical information necessary to process this insurance claim and/or referral(s).

Signed: _____ Date: _____

I authorize payment of medical benefits to undersigned physician or supplier

Signed: _____ Date: _____

I certify that all the above information is true and complete. I have read the payment policy and understand it.

Signed: _____ Date: _____

I acknowledge that I have received and/or read the Notice of Privacy Policy and Procedures and that I have had any questions regarding this notice answered to my satisfaction.

Signed: _____ Date: _____
Patient /Patient representative signature

Signed: _____
AIMC, PC representative