PATIENT REGISTRATION

DEMOGRAPHIC INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ (mm/dd/yyyy) SEX: _____ RACE: _____

SOCIAL SECURITY #:_____ ETHNICITY: _____

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ STATE:_____ ZIP: _____

LANGUAGE: _____ LANGUAGE COUNTRY:_____

MARITAL STATUS: ☐SINGLE ☐ MARRIED ☐ PARTNER ☐ DIVORCED ☐ WIDOWED

☐ PREGNANT (check if applicable) ☐ NURSING (check if applicable)

Whom may we thank for referring you to our practice? _____

CONTACT INFORMATION

HOME PHONE: _____ WORK PHONE: _____ EXT:_____

CELL PHONE: _____ EMAIL: _____

EMERGENCY CONTACT INFORMATION

CONTACT FIRST NAME: _____ CONTACT LAST NAME: _____

CONTACT HOME PHONE: _____ CONTACT CELL PHONE: _____

RELATIONSHIP TO PATIENT: _____ CONTACT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FAMILY MEMBERS IN THE PRACTICE

_____ (name) _____ (relationship to patient)
_____ (name) _____ (relationship to patient)
_____ (name) _____ (relationship to patient)
_____ (name) _____ (relationship to patient)

PRIMARY CARE / OTHER PHYSICIAN

PHYSICIAN NAME: _____ PRACTICE NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHARMACY NAME: _____ PHARMACY PHONE: _____

PHARMACY LOCATION: _____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE COMPANY: _____ CO-PAY: _____

GROUP #: _____ SUBSCRIBER #: _____

INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____

SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY:_____ STATE: _____ ZIP: _____

PHONE #: _____ EXT: _____

ADVANCED DIRECTIVE? ☐ YES ☐ NO WHERE IS IT FILED? _____(what medical facility?)

INSURED EMPLOYED BY: _____ BUSINESS ADDRESS: _____

CITY: _____ STATE _____ ZIP:_____ BUSINESS PHONE #: _____

ADDITIONAL INSURANCE

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE? ☐ YES ☐ NO

INSURANCE COMPANY: _____ CO-PAY: _____

GROUP #: _____ SUBSCRIBER #: _____

INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____

SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY:_____ STATE: _____ ZIP: _____

PHONE #: _____ EXT: _____

INSURED EMPLOYED BY: _____

BUSINESS ADDRESS: _____ CITY: _____ STATE _____ ZIP:_____

BUSINESS PHONE # : _____

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EMPLOYMENT STATUS: ☐ Employed ☐ Unemployed ☐ Full Time Student ☐ Part Time Student ☐ Retired

LAST DEGREE EARNED: ☐ HIGH SCHOOL ☐ COLLEGE ☐ GRADUATE SCHOOL

OCCUPATION: _____ BUSINESS NAME: _____

BUSINESS PHONE: _____

DRIVERS LICENSE #: _____ STATE ISSUED: _____

IS THIS AN ACCIDENT? ☐ YES ☐ NO

DATE OF INJURY _____

IS THIS A MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT
By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:** _____

By signing I acknowledge that I have read and understood The Practice policies and received a copy for my own personal records

Patient Signature: _____ Date: _____

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by **My Family Doc** in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form. We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff. You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or heath care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I Hereby authorize My family Doc to release my patient medical Information as described below:

Name	Relationship	Medical/ billing	Phone number

I agree and consent to releasing information to me in the following manners:

Please initial

_____ Ok to leave a detailed message to this Phone number_____

_____ Leave call back number only _____

_____ Contact via work phone number_____

_____ Ok to fax _____

Signature:_____ **Date**_____

My Family Doc
Medical History

Name: _____ Date of Birth: _____

Past Medical History: (Check appropriate circle)

- o High blood pressure
- o Thyroid Problems
- o Heart Failure
- o Seizures / Epilepsy
- o Glaucoma
- o Cancer : Type & location_____
- o High Cholesterol
- o Kidney Disease
- o Heart Murmur
- o Depression
- o Anxiety
- o Diabetes
- o Arthritis
- o Stroke
- o Mitral Valve Prolapse
- o Anemia
- o Asthma
- o Migraines
- o **If others please list** _____

Please list any surgeries that you had in the past:

_____
_____
_____

List any Drug Allergies:

_____
_____

List all current prescribed medications: (list how often and dosages)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Family History: Does your family have any of the following? (Check Appropriate box)

	Mother	Father	Maternal Grandparent	Paternal Grandparent	Brother /Sister
High Blood pressure					
Heart attack/ Heart surgery					
Diabetes					
Stroke					
Thyroid Problems					
Mental Illness					
*__If others please list:__					

Social History: Please answer the following

Do you use Tobacco Products? _____ What Kind? _____ How much? _____ For how many years? _____ Date Quit? _____	Do you drink Alcohol? _____ How many drinks per week? _____ Do you use Drugs? ____ What type? _____ How often? _____

Preventative care: When was your last?

Tetanus Booster_____ Flu shot: _____ Pneumonia Vaccine_____

Colonoscopy_____ Mammogram_____ Pap smear_____

My Family Doc
Dr. Molly D'costa DO
2001 Essington Rd
Joliet, IL 60435
815-733-6888 Fax 815-733-6890

*****Please Read and keep for your records******

Practice Policies

We welcome you to our practice! In order to better serve you, we would like to outline our practice policies. The information that follows is intended to answer any questions that you may have and to help you to be well informed. Please remember, should you have any additional questions, please let us know and one of our staff members will be happy to assist.

1. **Cancellations**: If you must cancel your appointment, we would appreciate your doing this at least 24 hours in advance so that another patient may use your appointment time. Please note that your account will be charged a $25.00 no-show, no-cancellation fee.

2. **New Patients:** We require our new patients to bring the following to their first appointment:
   a. A co-payment if you're insurance requires one. We accept cash, checks, and credit cards and require you to pay this amount upon registration and check-in.
   b. Your insurance card(s) & proof of identification (i.e. driver's license)
   c. A complete list of your medications including dosages
   d. Any questions you may have for the doctor

3. **Insurance Plans:** Since payment of charges for services provided to you is ultimately your responsibility, we encourage you to call your insurance company to verify your coverage for visits to our office. We also encourage you to confirm that Dr. D'costa is a provider in your insurance network.

4. **Laboratory Charges**: We send specimens to Quest Laboratory for analysis. If your insurance requires that we use a different laboratory, we must know this at the time of your registration and you must provide us with the proper implements/documents for processing. We will then require you, the patient, to take the specimen to your laboratory of choice for processing. We must inform you that it is your responsibility to ensure that we submit specimens to your correct laboratory.

5. **Account Balances:** As a courtesy to you, we will submit the charges for your visit to your primary and if applicable, secondary insurance carriers. We will send a statement to you for your portion of these charges after your insurance has paid. Your balance is due and payable upon receipt of your statement.
Any balance over 60 days old will be considered delinquent and subject to our collection process.

6. **Prescription Refills**: We encourage you to call your pharmacy and have the pharmacist fax a request for a refill to us during normal business hours. Our fax number is 815-733-6890. Please allow 24 – 48 hours for processing of your refill.

7. **Completion of Forms/FMLA:** We are happy to assist you with completion of forms for your insurance carrier or disability insurance. ***We request that you complete your personal information such as, name and address, etc. PRIOR to submitting them to our staff*** for completion. Our **fee for these forms is $30**.
Please allow 7-10 days for the processing.

8. **Medical Records:** If you need copies of your medical records, we request that you complete our Medical Release
Request Form which we can fax to you upon request, or you can print it off of our web-site at www.my-family-doc.com We do charge for our cost of preparing copies of your records as allowed by Illinois law. This charge varies with the number of pages we are required to process. Please allow 5 business days for the duplicating/processing of medical records.

My Family Doc

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

OUR PLEDGE REGARDING HEALTH INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive from us because we need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. It will also describe your rights and certain duties we have regarding the use and disclosure of
medical information.

1. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we are permitted to use and disclose medical information. Not every use or disclosure is listed, but each use or disclosure falls into one of these categories. Any use or disclose of your medical information for any purpose not listed below requires a written consent from you, which you may revoke at any time in writing to us.

For Treatment:

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are involved in your care. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process.

For Payment:

We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party. For example, we may need to give your insurance company information about your office visit so your insurance plan will pay us or reimburse you for the visit.

For Health Care Operations:

The use and disclosure of health care information may be necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to evaluate the performance of our staff in caring for you. We may also use information for accreditation, certificates, licenses, and credentials we need to serve you. We may use health care information in providing appointment reminders to our patients.

NOTICE OF PRIVACY PRACTICES

This notice takes effect on February 6, 2013 and remains in effect until we replace it.

Additional Uses and Disclosures:

In addition to using and disclosing your medical information for treatment, payment, and health care
operations, we may use and disclose medical information for the following purposes:

- As Required By Law To Avert a Serious Threat to Health or Safety
- Disaster Relief Specialized Government Functions (Military and Veterans)
- Workers' Compensation Court Orders, Judicial & Administrative Proceedings
- Public Health Risks Victims of Abuse, Neglect, or Domestic Violence
- Health Oversight Activities Law Enforcement

2. YOUR INDIVIDUAL RIGHTS

You have a right to inspect and copy your medical information.
You must make your request in writing to the attention of Medical Records and allow two weeks for processing. We will request that you complete our release form and pay a fee of $10.00 to cover our cost of copying the records.

You have the right to amend your information.
If you feel that your health information is incorrect or incomplete, you may request an amendment in writing to the privacy officer listed below. You must provide a reason that supports your request.

You have the right to an accounting of disclosures
You may request a listing of disclosures of your health information made for purposes other than treatment, payment, or operations. Your request must be submitted per directions below.

You have the right to request restrictions on information released
For example, you could ask that we not disclose information to your spouse about a surgery you had. We are not required to agree to your request if we feel it will have a negative impact on your care. If we do agree, we will abide by our agreement. Your request must be submitted per directions below.

You have the right to request confidential communications
You may request that we communicate with you about health matters in a certain way or at a certain location. For example, you may ask that we only contact you at work. Your request must be submitted per directions below.

NOTE: All requests for information or other specific requests must be in writing and directed to Carolyn Longi, the Privacy Officer at the address listed in #4 below. Please allow 14 days for a response.

NOTICE OF PRIVACY PRACTICES

This notice takes effect on February 6, 2013 and remains in effect until we replace it.

3. OUR LEGAL DUTY

We are legally required to: Keep your medical information private. Provide you with this notice regarding our legal duties, privacy practices, and your rights regarding your medical information. Follow the terms of this notice that is now in effect

We have the right to: Change our privacy practices and the terms of this notice at any time, provided the changes are permitted by law. Make the changes effective for all medical information that we keep, including information previously created or received before the change.

We will: Make any changes in our privacy practices available upon request before we implement them.

4. QUESTIONS AND COMPLAINTS

Please address questions or complaints to Practice Manager, c/o Dr. Molly D'costa ; 2001 Essington Road; Joliet, IL 60435; phone 815-733-6888

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If you think that we may have violated your privacy rights, contact the person named above. You may also submit a written complaint the US Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.