PATIENT INFORMATION FORM

Patient Name _____ Date of Birth: _____
Last First Middle

Address: _____
Street City State Zip

Phone Number: (____) _____ - _____ Social Security #: _____ - _____ - _____
Marital Status: Single / Married / Widowed / Divorced

E-Mail: _____
Would you like for us to contact you through email appointment through e-mail? ___ Yes _____ No

Emergency Contact: _____ Phone Number: (____) _____ - _____

Emergency contact relation?_____

How did you hear about the practice? _____

Employment Information:

Employer: _____ Occupation: _____

Address: _____
Street City State Zip

Phone Number: (____) _____ - _____ Employed Since: _____ / _____ / _____

Were you injured on the job? _____ Yes _____ No

Please complete the section below if someone other than patient is responsible for the bill

Responsible Billing Party: _____ Date of Birth: _____
(For Insured)

Address: _____
Street City State Zip

Phone Number: (____) _____ - _____ Work Phone: (____) _____ - _____

Employer:_____ Relationship to patient:_____

Personal Information

Primary
Name of Insurance:_____

Co-Payment: $_____ Deductible: $ _____
Effective Date: _____

Secondary
Name of Insurance:_____

Co-Payment: $_____ Deductible: $ _____
Effective Date: _____

Insurance Authorization and Assignment

I hereby authorize Rita Oganwu M.D. to furnish information to insurance carriers concerning my illness/treatments and I hereby assign to the Doctor **ALL** payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount **NOT** covered by insurance.

Patient's Signature: _____ Date: _____

Insured Signature: _____ Date: _____

HIPAA RELEASE FORM

I,_____ acknowledge that I (we) received and read the Privacy Policy of Dr. Rita N. Oganwu as set forth in the Privacy Policy brochure so named.

_____ Date _____

Financial Policy

We appreciate that you have entrusted us with your health care. Because healthcare benefits and coverage options have become increasingly complex, we have developed this policy which details our financial requirements to help you better understand your responsibilities as a patient.

Its is your responsibility to know if your insurance has specific rules or regulations, such as the needs for referrals, pre-certifications , limits on outpatient charges, specific physicians and/or hospitals to use. You should be knowledgeable of any deductions, co-payments, and /or coinsurance. This applies to all payers regardless of whether or not our physicians participate.

The responsibility for payment of fees for services is the direct responsibility of the patient. Your health benefit plan is an arrangement between you, the enrollee and the insurance company, or your employer. Your health benefit plan determines your coverage, requirements, and establishes the limit on your coverage for medical services based on what they determine as medically necessary. However, we will do our best to assist you with understanding your proposed treatment and in answering questions related to your insurance.

Payment Policy Schedule*:

Co-payments	Full payment is due at time of service
Deductibles and coinsurance	Full office visit charges are due at time of service
Non-covered service	Full payment is due at time of service
Non-participating insurance plan	Full payment is due at time of service

Other charges/fees*:

Missed appointment Fee — Our office requires at least 24 hours' notice when cancelling an appointment. Failure to provide this will result in a $30.00 charge to your account.

Past Due Statement Fee — A $30.00 charge will be applied to each past due statement issued for outstanding bills 90 days or more.

Return Check Fee — Checks are ONLY accepted at our office if they are mailed in and are covering an invoice balance. In the event that the check is returned due to insufficient funds, there will be a $25.00 fee applied to your account.

Medical Records Fee: **According to IL ST CH 735 SS8-S003, charges for medical records are as follows:**
Medical Search Fee & Handling charge: $25.00
Per Page Fee:
$.97 per page for 1-25 Pages * $.65 per page for 26 -50 pages * $.32 per page for 50+ pages
Microfiche per page charge: $1.62 * Mailing Fee: Actual cost of postage

***subject to change at any time**

We realize that medical care can often become very expensive. If you have concerns about your ability to pay for service, we recommend that you contact us for assistance in the management of your account.

Should you have any questions with regard to our financial policy we encourage you to ask. It is our goal, not only to provide the best quality of medical care, but to help you by answering any questions you may have.

I _____ have read and agree to the above terms of the stated financial policy. I understand that I am responsible for all payments not covered by my insurance carrier along with any fees that I have incurred that are listed in this financial policy.

Patient's Signature:_____ Date:_____