Welcome To Our Office

AURORA INTERNAL MEDICINE CLINIC P.C.

PLEASE PRINT and COMPLETE ALL PARTS

Patient Number _____ Today's Date _____

PATIENT NAME: (This section refers to PATIENT ONLY)

Name _____ Age _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Sex ____ Social Security # _____ Employer _____ Email _____

Spouse _____ Employer _____ Work Phone _____

Relationship to Responsible Party ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Other

RESPONSIBLE PARTY: (Person who should receive the bill)

Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Social Security # _____

Date of Birth _____ Age _____ Employer _____

HOW DID YOU HEAR ABOUT US?: _____

REFERRING PHYSICIAN NAME (PCP): _____ **PHONE:** _____

INSURANCE: (Please complete thoroughly. We will need a copy of your insurance card.)

Primary Insurance _____	Secondary Insurance _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
Phone: Area ( ) _____	Phone: Area ( ) _____
Primary Insured Person _____	Primary Insured Person _____
ID/Policy # _____ Suffix _____	ID/Policy # _____ Suffix _____
Group # _____	Group # _____
Employer _____	Employer _____
Co-Payment $ _____	Co-Payment $ _____
Auto Injury ☐ Claim # _____	Date of Accident _____
Work Comp ☐ Claim # _____	Date of Accident _____
Other Injury (Specify) _____	Date of Accident _____

NOTIFY IN EMERGENCY: (NOT LIVING WITH YOU)

Name _____ Relationship _____ Phone _____

CONSENT FOR TEST RESULTS I give Aurora Internal Medicine Clinic P.C. permission to leave all X-ray, appointments, lab results, test results, and other medical information and advice on: (check all that apply) ☐ Voice mail at work ☐ Answering machine at home ☐ Cell Phone ☐ Okay to leave message with family member ☐ Do not leave message ☐ Other _____

I hereby acknowledge that I have received a copy of Aurora Internal Medicine Clinic P.C. Notice of Privacy Practices. I authorize the release of any medical information and payment of medical benefits to the physician 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: (check one) ☐ 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 $20.00 charge on all returned checks. A $15.00 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 accessed $20/month 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 your bill is turned over to a collection agency, collection fees, attorney's fees, and court costs will be added to your account balance and you and your family will be dismissed from our 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 24 hours notice may be charged $25-$40 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.

REGARDING MEDICAL RECORDS

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

NOTICE AND ACKNOWLEDGEMENT OF PRIVACY POLICY AND PROCEDURES

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), AIMC, P.C. may not use or disclose your personal health information without your authorization. THE PRACTICE HAS POLICIES AND PROCEDURES TO COMPLY WITH HIPAA LAW. EVERY ATTEMPT HAS BEEN MADE TO KEEP THE PROCESS FOR PATIENTS AND STAFF AS EFFICIENT AS POSSIBLE. HOWEVER, THE REQUIREMENTS ARE EXTENSIVE AND TAKE TIME, EFFORT, AND COOPERATION TO PROCESS 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 in the waiting room 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, P.C. Representative