New Patient - Barrington Family Medicine

Last Name: _____ ***First Name***: _____

Date of Birth: _____ ***Sex*** (circle one): M F T Will not disclose

Social Security Number: _____

Race (circle one): American Indian Asian Pacific Islander African American Caucasian Hispanic Other

Ethnicity (circle one): Hispanic/Latino Non-Hispanic/Latino Will not disclose

Address: _____

_____

Phones:

Home: _____ Cell: _____ Work: _____

Email: _____

An email is required to access the patient portal to manage your account. You can make appointments, update demographics, view and pay statements and also view your medical records, medications, visit summaries and lab results.

Employment Status (circle one): Full time Part Time Retired Unemployed

Current Medications:

Name Dose Frequency

_____

_____

_____

_____

_____

_____

Pharmacy:

Name and Address

_____

_____

BARRINGTON FAMILY MEDICINE

PATIENT INSURANCE VERIFICATION FORM

Patient Name(s): _____

_____

_____

_____

Primary Insurance Provider: _____
(example Medicare, Blue Cross Blue Shield, Aetna, etc.)

Secondary Insurance Provider: _____
(enter if applicable)

If the insurance provided is invalid, a $25 fee will be charged to reprocess **each** claim.

Please sign below to confirm your understanding of this policy. Thank you.

_____ _____

Patient signature Date

PLEASE ATTACH A PICTURE OF THE FRONT AND BACK OF YOUR INSURANCE CARD(S). THANK YOU.

HIPAA AUTHORIZATION

I, _____, **DO** or **DO NOT** (circle one) give my permission for any results, or appointment-related information, to be left on my voicemail at the following number if I am unable to answer the call. (____) _____

I, _____ give permission to Dr. Bartolomeo, Chelsea Newren APRN to use and disclose my protected health information including medical, treatment and diagnostic records to the following individuals. Please include name and relation to patient.

- _____
- _____
- _____

_____ _____

Signature of Patient or Authorized Representative **Relationship**

_____

Printed Name of Patient or Authorized Representative

_____

Date

Emergency Contact

Please provide us with contact information in case of an emergency.

Name: _____ Ph: _____ Relation: _____

Name: _____ Ph: _____ Relation: _____

OFFICE & FINANCIAL POLICIES

(YOU MUST INITIAL EACH POLICY)

1. **Insurance:** The patient, guardian, or parent (if patient is a minor), is responsible for knowing his/her benefit coverage. We will file your insurance claim on your behalf. However, we WILL NOT become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria. We will supply any information necessary. You are responsible for all non-covered charges and services. We may have you sign a WAIVER OF LIABILITY for any service that we think may not be covered by insurance. _____ (initial)
2. **Co-Pays and Account Balances:** Co-pays are due at the time of service, along with any outstanding account balance. There is a $50 fee for returned checks. _____ (initial)
3. **Self-Pay:** Payment in full is expected at the time of service. _____ (initial)
4. **Referrals:** It is the patient's responsibility to know if referrals are required for specialist's visits and to inform his/her Primary Care Physician. On average, please allow up to 4 business days to process referrals. If a referral re-issuance is required, a $25 service charge will be assessed. _____ (initial)
5. **Check-In:** Please bring your CURRENT insurance card(s) to EVERY visit to allow for proper and timely claim filing; otherwise, you will be considered self-pay or asked to reschedule. You will also be asked at every visit to verify demographic information. If the wrong insurance information is given, you will be charged a $25 claim resubmission fee. _____ (initial)
6. **Late Arrivals:** If you arrive to your appointment more than 15 MINUTES past your scheduled time, you will be asked to reschedule. _____ (initial)
7. **No-Shows:** Any missed appointment without 24-hour notification prior to your scheduled time results in a $50 no-show fee (also applies to same day appointments). _____ (initial)
8. **Late Fees:** All invoices are due within 30 days from the statement issue date. A late fee of $20 per month will be charged for overdue accounts. _____ (initial)
9. **Minors:** Unaccompanied minors (18 and under) must have a written and signed (by parent or guardian) authorization for medical treatment at the time of check-in. _____ (initial)

I have read, understand, and agree to the above office and financial policies.

Patient name: _____ *DOB:* _____

Patient/Guardian Signature: _____

Power of Attorney for Health Care Illinois Statutory Short Form

This Power of Attorney revokes all previous Powers of Attorney for Health Care.
You must sign this form and a witness must also sign it before it is valid.

My name (print your full name): _____

My address: _____

☐ **Please check box if applicable** – I DO NOT HAVE A POWER OF ATTORNEY and sign on page two.

I want the following person to be my health care agent (an agent is your personal representative under state and federal law):

Agent name: _____ **Agent phone number:** _____

Address: _____

☐ **Please check box if applicable** – If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as guardian.

Successor health care agents (optional):

If the agent I selected is unable or does not want to make health care decisions for me, then I request the person(s) I name below to be my successor health care agent(s). Only one person at a time can serve as my agent (add another page if you want to add more successor agent names).

Successor agent #1 name: _____ **Phone number:** _____

Address: _____

Successor agent #2 name: _____ **Phone number:** _____

Address: _____

My agent can make health care decisions for me, including:

- Deciding to accept, withdraw, or decline treatment for any physical or mental condition of mine, including life and-death decisions.
- Agreeing to admit me to or discharge me from any hospital, home, or other institution, including a mental health facility.
- Having complete access to my medical and mental health records, and sharing them with others as needed, including after I die.
- Carrying out the plans I have already made, or, if I have not done so, making decisions about my body or remains, including organ, tissue or whole-body donation, autopsy, cremation, and burial.

The above grant of power is intended to be as broad as possible so that my agent will have the authority to make any decision I could make to obtain or terminate any type of health care, including withdrawal of nutrition and hydration and other life-sustaining measures.

I authorize my agent to (please check ONLY one box):

☐ Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability.

(If no box is checked, then the box above shall be implemented.) ** OR **

☐ Make decisions for me starting now and continuing after I am no longer able to make them for myself. While I am still able to make my own decisions, I can still do so if I want to.

Power of Attorney for Health Care Illinois Statutory Short Form

The subject of life-sustaining treatment is of particular importance. Life-sustaining treatments may include tube feedings or fluids through a tube, breathing machines, and CPR. In general, in making decisions concerning life-sustaining treatment, your agent is instructed to consider the relief of suffering, the quality as well as the possible extension of your life, and your previously expressed wishes.

Your agent will weigh the burdens versus benefits of proposed treatments in making decisions on your behalf.

Additional statements concerning the withholding or removal of life-sustaining treatment are described below. These can serve as a guide for your agent when making decisions for you. Ask your physician or healthcare provider if you have any questions about these statements.

Select only one statement below that best expresses your wishes (**OPTIONAL**).

- ☐ The quality of my life is more important than the length of my life. If I am unconscious and my attending physician believes, in accordance with reasonable medical standards, that I will not wake up or recover my ability to think, communicate with my family and friends, and experience my surroundings, I do not want treatments to prolong my life or delay my death, but I do want treatment or care to make me comfortable and to relieve me of pain.
- ☐ Staying alive is more important to me, no matter how sick I am, how much I am suffering, the cost of the procedures, or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards.

Specific limitations to my agent's decision-making authority:

The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make to obtain or terminate any type of health care. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power to authorize autopsy or dispose of remains, you may do so specifically in this form.

_____

_____

My signature: _____ **Today's date:** _____

Have your witness agree to what is written below, and then complete the signature portion:

I am at least 18 years old. (check one of the options below):

- ☐ I saw the principal sign this document, or
- ☐ The principal told me that the signature or mark on the principal signature line is his or hers.

I am not the agent or successor agent(s) named in this document. I am not related to the principal, the agent, or the successor agent(s) by blood, marriage, or adoption. I am not the principal's physician, advanced practice nurse, dentist, pediatric physician, optometrist, psychologist or a relative of one of those individuals. I am not an owner or operator (or relative of an owner or operator) of the health care facility where the principal is a patient or resident.

Witness printed name: _____

Witness address: _____

Witness Signature: _____ **Date Signed:** _____

BARRINGTON
FAMILY MEDICINE

I understand that I am here for an Annual Physical/Annual Wellness Exam and there is no co-pay for this service. Insurance will typically cover this visit one time per year. However, if the provider seeing you today discusses anything outside of the Annual Physical/Annual Wellness Exam, you will be billed for an office visit as well as the co-pay. Examples of chronic care conditions you may be billed for during this visit consist of diabetes, hypertension, acute illness, thyroid disorders, medication checks, etc.

If you have any questions, please ask so we can clarify this for you further. Thank you for your cooperation and understanding.

Printed Name:_____

Signature:_____

****By signing this form, I am also acknowledging that I received an informative handout (next page) with more detail regarding what is and is not considered a physical/preventative care visit.*****

Date:_____

****Patient Copy****

PLEASE KEEP THIS PAGE FOR YOUR RECORDS.

What is a physical/preventative care visit?

A physical/preventative care visit is "The review of medical and social health history, and preventative services education". An exam performed without relationship to treatment or a diagnosis for a specific illness, chronic condition, symptom, complaint or injury.

Services Include: routine yearly screening services, a full review of the body, and possibly routine bloodwork (if applicable).

*** If an abnormality is encountered or a pre-existing condition is addressed in the process of performing this preventative evaluation and management service, ***then an office visit will also be billed.*** ***

Barrington Family Medicine - Medicare Annual "Wellness" Visit

If you've had Medicare Part B (Medical Insurance) for longer than 12 months, you can get a yearly "Wellness" visit to develop or update your personalized plan to help prevent disease or disability, based on your current health and risk factors. **The yearly "Wellness" visit isn't a physical exam.**

Your Costs in Original Medicare

You pay nothing for this visit if your doctor or other qualified health care provider accepts assignment. The Part B deductible doesn't apply. However, you may have to pay coinsurance and the Part B deductible may apply if:

- Your doctor or other health care provider performs additional tests, labs or services during the same visit. Medicare doesn't cover these additional tests, labs or services under this preventive benefit. If Medicare doesn't cover the additional tests, labs or services (like a routine physical exam), you may have to pay the full amount.

Description of Annual Wellness Visit

Your provider will ask you to fill out a questionnaire, called a "Health Risk Assessment," as part of this visit. Answering these questions can help you and your provider develop a personalized prevention plan to help you stay healthy. Your visit may include:

- A review of your medical and family history.
- A review of your current providers and prescriptions.
- Height, weight, blood pressure, and other routine measurements.
- Personalized health advice.
- A list of risk factors and treatment options for you.
- A screening schedule (like a checklist) for appropriate preventive services.
- Your provider will also perform a cognitive assessment to look for signs of dementia, including Alzheimer's disease. Signs of cognitive impairment include trouble remembering, learning new things, concentrating, managing finances, and making decisions about your everyday life. If your provider thinks you may have cognitive impairment, Medicare covers a separate visit to do a more thorough review of your cognitive function and check for conditions like dementia, depression, anxiety, or delirium and design a care plan.

Permission to Perform Additional Tests, Labs or Services

I, the undersigned, acknowledge that additional tests, labs or services were performed during my Annual "Wellness" Visit. I understand that I am financially responsible for any costs not covered by Medicare.

_____ _____

Print full name of patient Signature of patient

_____

Date

RELEASE OF MEDICAL RECORDS

Information regarding patient for whom authorization is made:

Full Name: _____ Date of Birth: _____

Phone: _____

Information regarding health care provider or health care entity authorized to disclose:

Name: _____

Phone: _____ Fax: _____

Information regarding person or entity who can receive and use this information:

Name: Orazio Bartolomeo, MDSC / Chelsea Newren APRN

Address: 120 N. Northwest Highway, Barrington IL 60010

Phone: (847) 382-6579 Fax: (847) 382-7194 Email: barringtonfamilymedicine@gmail.com

Specific Information to be disclosed:

- ☐ Medical record from: _____ to _____
- ☐ Entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.
- ☐ Other: _____

The individual signing this form agrees and acknowledges as follows:

1. **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.
2. **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month _____ Date _____ Year _____.
3. **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. **Special Information:** I must initial one or more of the following types of health information that I do not want released to the above-named recipient(s). I understand that if I do not initial any of the three (3) following lines, the health information released to the above-named recipient(s) may include any of the following:
   _____ **(initial) DRUG, ALCOHOL AND SUBSTANCE ABUSE**
   _____ **(initial) MENTAL HEALTH INFORMATION (except psychotherapy notes)**
   _____ **(initial) CONFIDENTIAL HIV/AIDS-RELATED INFORMATION, AND GENETIC INFORMATION**
5. **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient(s) and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative: _____ Date: _____

If Legal Representative, relationship to patient: _____