Prestige Clinics

Welcome! Thank you for completing the:
New Patient Registration Form

Please Print

Today's Date	

PATIENT INFORMATION

Full Legal Name (First) (Middle) (Last)					Name Normally Used (Nickname)
Address	Apt. No.	City	State	Zip	
E-mail	Home Phone	Work Phone	Cell Phone		
Social Security No.	Sex	Marital Status	Date of Birth	Driver's License No.	State Issued
Employer Name	Employer City	Employer State	How Did You Hear About Us?		
List anyone you authorize this office to share your medical information with (name and relationship to you)					
Permitted Contact Method(s) (circle all that apply) home phone cell phone work phone mail e-mail					Ok to leave message on answering machine/voicemail? Yes___ No___

SPOUSE'S INFORMATION

Full Legal Name (First) (Middle) (Last)			Home Phone
Occupation	Employer name	Work phone	Cell Phone

FAMILY OR FRIEND #1 INFORMATION

Full Legal Name (First) (Middle) (Last)			Home Phone
Occupation	Employer name	Work phone	Cell Phone

FAMILY OR FRIEND #2 INFORMATION

Full Legal Name (First) (Middle) (Last)			Home Phone
Occupation	Employer name	Work phone	Cell Phone

FAMILY OR FRIEND #3 INFORMATION

Full Legal Name (First) (Middle) (Last)			Home Phone
Occupation	Employer name	Work phone	Cell Phone

FAMILY OR FRIEND #4 INFORMATION

Full Legal Name (First) (Middle) (Last)			Home Phone
Occupation	Employer name	Work phone	Cell Phone

FAMILY OR FRIEND #5 INFORMATION

Full Legal Name (First) (Middle) (Last)	Home Phone

Occupation	Employer name	Work phone	Cell Phone

FAMILY OR FRIEND #6 INFORMATION

Full Legal Name (First) (Middle) (Last)			Home Phone
Occupation	**Employer name**	**Work phone**	**Cell Phone**

FAMILY OR FRIEND #7 INFORMATION

Full Legal Name (First) (Middle) (Last)			Home Phone
Occupation	**Employer name**	**Work phone**	**Cell Phone**

FAMILY OR FRIEND #8 INFORMATION

Full Legal Name (First) (Middle) (Last)			Home Phone
Occupation	**Employer name**	**Work phone**	**Cell Phone**

INSURANCE INFORMATION

Primary Insurance Company Name		Group No.	ID/Certificate No.
Policy Holder's Name/Parent's Name (if patient a child)	**D.O.B.**	**Policy Holder's Social Security No.**	
Secondary Insurance Company Name		**Group No.**	**ID/Certificate No.**
Policy Holder's Name			

EMERGENCY INFORMATION

Person to Notify in Case of Emergency	Relationship	Home Phone	Cell Phone

INFORMATION FOR THE PATIENT

1. Patients who carry standard health insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. All patients with standard health care insurance are expected to make payment as services are rendered, regardless of pending insurance, litigation, etc.
2. Patients with contract health plans should present their insurance ID card to the receptionist after completing this form. Some contract health plans (HMOs, PPOs, IPAs, etc) require a copayment at the time of service. Most contract health plans require that the claim be submitted by our office.

Patient/ Guarantor Signature: ✖ _____ Date: _____

Prestige Clinics

Patient Rights Regarding Medical Records

***All requests to inspect, copy, amend, restrict, or share health information must be made in writing on the proper forms which will be provided upon request. All changes to preferred forms of communication must also be made in writing.**

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records.

If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. This review will be conducted by another licensed health care professional chosen by our practice. The person conducting the review will not be the person who denied your request. This practice will comply with the outcome of the review.

Right to Amend: If you believe that health information we have about you is incorrect or incomplete, you may ask us to amend the information. We may deny your request for an amendment if it is not in writing or does not include a reason for the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the health information kept by or for our practice
- Is not part of the information that you would be permitted to inspect and copy
- Is accurate and complete

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures: You have the right to request a list of the disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively affect the care we provide you.

Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location.

Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this notice at any time. To obtain a copy, please request it from any staff member.

Changes to This Notice

We reserve the right to change this notice and apply it to any past, present, or future health information we have about you. We will post a copy of the most current notice in our facility with the effective date on the first page. You may request a copy of our most current notice at any time.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. **You will not be penalized for filing a complaint.**

Other Uses of Health Information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. You have the right to revoke this permission for any health information that has not yet been shared.

Confidentiality and Privacy of Medical Records

This notice describes the privacy practices of our office. PLEASE REVIEW CAREFULLY.

Our Pledge Regarding Health Information

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) was drafted, in part, to control the privacy of, access to, and maintenance of confidential information. We understand that information about you, your health, and your health care is personal. We are committed to protecting your personal health information (PHI).

We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by this health care practice, whether made by your personal physician or others working in this office. This notice will tell you about the ways in which we may use and disclose your PHI. We also describe your rights to the PHI we keep about you, and describe certain obligations we have regarding the use and disclosure of your PHI.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to your PHI
- Follow the terms of the notice that is currently in effect

How We May Use and Disclose Your PHI

The following categories describe different ways that we use and disclose health information.

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to others involved in your healthcare treatment including other physicians, hospitals, labs, pharmacies, or other health care providers where we may have referred you.

For Payment: We may use and disclose information about treatment and services we provided to you for billing purposes. These fees may be collected from you, an insurance company, or a third party and include requests for payment/reimbursement and prior authorization for treatment..

Appointment Reminders: We may use and disclose health information to contact you as a reminder that you have an appointment or that you missed an appointment and should contact us to reschedule. Please let us know if you do not wish to have us contact you for this purpose or if you wish us to use a different method to contact you.

As Required by Law: We will disclose health information about you when required to do so by federal, state, military, or local law.

Organ and Tissue Donation: If you are an organ donor, we may release health information to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to the health and safety of you or another individual(s).

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health reporting purposes. These activities generally include but are not limited to the following:

- Birth, death, abuse, neglect, communicable disease prevention and/or notification, medication adverse reactions, and product recalls.

Coroners, Health Examiners, and Funeral Directors: We may release health information to a coroner, health examiner, or funeral directors as necessary to carry out their duties.

Prestige Clinics

Patient Medical History Form

★ NAME: _____ AGE: _____ DATE: _____

PHYSICIAN you were seeing previously:

Other SPECIALISTS you currently see: _____

_____

MEDICAL PROBLEMS (including present conditions):

List all CURRENT PRESCRIPTION MEDICINES (include dosage, reason you take it, who prescribed it):

List all OVER-THE-COUNTER MEDICINES, vitamins, and food supplements that you take:

ALLERGIES TO MEDICATIONS (including reaction): _____

_____

★ List SURGERIES you have had (include year, surgeon, and hospital):

★ Describe HOSPITALIZATIONS/ILLNESSES not included above (include year, hospital):

★ **Have you had (circle):**	migraines	hepatitis	mono	ulcer
bleeding problem	blood clots	head injury	drug addiction	gallstones
tuberculosis	STDs	seizures	memory trouble	arthritis
psoriasis	heart murmur	rheumatic fever	polio	shingles
alcoholism	depression	mental illness	gout	hemorrhoids
hearing trouble	vision trouble	other	_____	_____

Ethnicity (circle): Hispanic or Non-Hispanic **Race:** _____ **Preferred Language(s):** _____

Do you have a Living Will? Yes No If Not, are you interested in having one? Yes No

★ **Do/did you SMOKE? Yes No** How much? _____ packs/day # of years _____ Year you QUIT _____

When was the last time you tried to quit? _____ How many times have you tried to quit? _____

How have you been successful in quitting in the past? _____

Do/did you DRINK alcohol? _____ How much? _____ drinks/week # of years _____

Year you QUIT _____ Previous or current problem with alcohol? _____ AA? _____

Do you or have you used (circle): heroin marijuana cocaine methamphetamine chewing tobacco diet pills

Do you have a history of prescription drug abuse or addiction? _____ If yes, which one(s)? _____

Prestige Clinics

Patient Medical History Form

★ WOMEN

Age at first period _____ Date of last normal period _____ # of pregnancies _____

# of live births _____ # of children living with you _____ # abortions/miscarriages _____

Problems with pregnancies (circle) pre-term labor toxemia diabetes high blood pressure other: _____

Birth control method _____

Date of last Pap _____ Result? _____ Done where? _____

Date of last mammogram _____ Result? _____ Done where? _____

Do you have (circle):

irregular periods	bad menstrual cramps	heavy periods	abnormal mammogram	abnormal Pap smear
pelvic pain	infertility	sexual difficulty	hot flashes	vaginal dryness
vaginal discharge	vaginal odor	vaginal itching	PMS	breast changes

★ ALL

Who in your *family* has/had (circle if cause of death and write age of death)

heart disease _____	genetic disorder
diabetes _____	cancer (what type?)
thyroid disease _____	alcoholism
mental illness _____	arthritis
glaucoma _____	asthma
allergies _____	stomach problems
tuberculosis _____	high blood pressure

List any other diseases that run in your family and specify your relationship to each family member listed.

★ **When was your last:**

tetanus shot _____ flu shot _____ pneumonia vaccine _____ hepatitis vaccine _____

TB test _____ colonoscopy _____ chest x-ray _____ EKG _____

Who lives with you?

Do you have any children? _____ If yes, list their names, ages, and any major medical problems _____

_____

_____

Where do/did you work? What line of work are you in? _____

What is the last grade in school you finished?

Anything else you would like us to know?

_____

Prestige Clinics

Patient Financial Responsibility

As a courtesy to our patients, we have enrolled in numerous managed care insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly. However, it is not possible for us to keep track of all the individual requirements of each plan.

It is the responsibility of each patient to know the details of his or her insurance plan in addition to any lapses in insurance coverage. Any charges that occur as a result of insurance plan restrictions or lapses in coverage are ultimately the patient's responsibility. Unfortunately, if you do not inform us of special requirements required by your plan and we order medically necessary services, such as lab work, hospitalization, or supplies that are not covered by your plan; we may bill you directly for those charges. If current insurance coverage cannot be verified prior to each appointment, payment will be due at the time of service.

The office bills only for services performed by our providers. Laboratories are separate entities and will bill you or your insurance company for services that are performed. If you have any questions about your laboratory bill please contact them or your insurance company directly.

Providing the highest quality of medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance plan guidelines, whenever possible. With your cooperation you should be able to receive all of the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care.

We may charge an upfront **$35.00 administrative fee** for completing forms such as disability or insurance and medical records requests. Please be aware that these services may require up to seven to ten days to complete.

If an account is not paid in full within 90 days, a **25% collection processing fee** will be added to the outstanding balance and will be turned over to a collection company for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

For patients selecting additional care services as part of the Prestige Method, we may charge an **upfront additional fee** commensurate to the level of patient engagement, focus on outcomes improvement, and comprehensive of delivery model. These services would be in addition to your insurance covered healthcare services.

We attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. Prestige Clinics also reserves the right to charge a no-show fee for patients who miss appointments without calling to cancel within 24 hours of the appointment. The current **no-show fee is $25.00** and is subject to change without notice.

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by myself.

BY SIGNING BELOW I ACKNOWLEDGE I HAVE READ AND UNDERSTAND THE FOLLOWING POLICIES. I ACCEPT THE RIGHTS AND RESPONSIBILITIES OUTLINED WITHIN THEM:

- **Patient Rights Regarding Medical Records**
- **Patient Financial Responsibility including collections, no-show policy**
- **Confidentiality and Privacy of Medical Records**

✖ _____ _____

Patient Signature Date

_____

Patient Printed Name

Prestige Clinics

Authorization to Release Medical Information

RELEASE TO:
Prestige Clinics
931 Ridge Road, Suite B
Munster, IN 46321
219-301-5477 office
219-246-4556 fax

3. **INFORMATION TO BE RELEASED:** (Check all applicable)
   ☐ All Information ☐ All Progress Notes ☐ Lab Reports ☐ X-ray Reports
   ☐ Electrocardiogram (ECG) ☐ Allergy Records ☐ Immunization Records ☐ Other:_____

SPECIAL AUTHORIZATION: Check applicable box(es) and sign immediately below.
By signing below, I am authorizing the office to release any and all information regarding:
☐ Alcohol ☐ Drugs ☐ Mental Health ☐ Sexually Transmitted Diseases ☐ HIV ☐ AIDS

Note: If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature: ✖_____ Date: _____

4. **RECORDS FROM THE TIME PERIOD:** / / through / /____

5. **PURPOSE OF DISCLOSURE:** (Check applicable purpose)
   ☐ Continued Medical Care ☐ Payment of Insurance Claim ☐ Legal
   ☐ Personal ☐ Workers' Compensation Claim ☐ Other:_____

6. I understand that this authorization shall be valid for five years. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

7. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

8. The requestor may be provided with a copy of this authorization.

Patient/Guardian Signature: ✖_____ Date: _____

Date of Birth: _____ Home Phone: _____ Work Phone: _____

For office use only:

MR# Date Initials of Staff Member Sending

Prestige Clinics

Medicare & Prestige Clinics now offers a new benefit for patients with multiple chronic diseases, and by consenting to this Agreement, you designate your provider, Prestige Clinics, PC to provide chronic care management (CCM) services per the new rule.

Only patients with more than one chronic condition are eligible for this benefit and your provider agrees not to bill Medicare for this service if you don't have more than one chronic condition. Medicare defines a chronic condition as one that is expected to last at least 12 months, and that increases the risk of death, acute exacerbation of disease, or a decline in function.

Provider Chronic Care Services As part of this new benefit, your Provider agrees to make available the following services:

1. 24/7 access to a healthcare provider to address your acute chronic care needs
2. Use of certified EHR software to document your care
3. Provide a written or electronic version of your care plan
4. Perform medication reviews and oversight
5. Assist in the management of transitions of care from one provider to another

In connection with this new benefit, your provider agrees to bill Medicare just one time per each 30-day billing cycle and if you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.

Beneficiary Consent Terms By signing this Agreement, you agree to the following terms required by Medicare:

1. You consent to your Provider providing CCM services to you.
2. You acknowledge that only one practitioner can furnish CCM Services to you during a thirty (30)-day period.
3. You authorize electronic communication of your medical information with other treating providers to facilitate the coordination of your care.
4. You understand that the Medicare Co-Insurance amount applies to CCM Services.

You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current thirty 30-day period of services by notifying our practice in writing.

Beneficiary or Caregiver Signature: ✖ _____

Print Name: _____

Date: _____

Prestige Clinics
931 Ridge Road, Suite B,
Munster, IN 46321
219-301-5477

Prestige Clinics

Scheduled Appointment Agreement

Your health care is important. WE ARE NOT AWARE of how your insurance company determines which services/labs are paid and which services/labs are not paid or which are subject to coinsurance or deductible. Some pay only for illness codes, and some only for prevention codes, and some do not pay for a myriad of other factors. Our responsibility to the patient is to provide care and order labs based on your individual medical needs and current prevention guidelines and the standard of medical care. There are no medical guidelines to support "routine labs" ordered without a medical evaluation whether it is a covered benefit or not. Please take the time to make yourself familiar with your insurance benefits. Feel free to call the insurance company and ask about coverage. There are many plans and their benefits change often we have no way of knowing what is current for you.

You may schedule an appointment as a WELL EXAM, PREVENTIVE CARE or ROUTINE EXAM. It will be billed as such to your insurance plan. Due to coding laws, we MUST bill your exam as Preventive Care. If during your visit you have ADDITIONAL CONCERNS or PROBLEMS that require a diagnosis and/or other treatment it would be considered a Problem Oriented Exam and you may incur additional office or lab charges. These charges and any from your Preventive Care Exam will be billed to your insurance company. You may want to keep your Well Exam separate from your Problem-Oriented Exam and we would be happy to schedule it that way for you.

If your insurance company does not cover some or all of these charges, you will be billed directly for the balance they indicate is "patient responsibility". Please DO NOT ASK US TO RE-BILL your insurance by changing the procedure or diagnosis codes. We are unable to make a change once the insurance has been billed.

Laboratory services are provided by third party and have no direct financial or other affiliation with Prestige Clinics. This means the laboratory work done is billed entirely by those individual companies. The services and billing remains the same regardless of whether you had those laboratory services done at Prestige Clinics or at an outside laboratory. The laboratory service, therefore, is offered as a convenience to our patients. If a billing question about laboratory service occurs, it is the responsibility of the patient to direct those questions to the laboratory billing department and please note that we will not change codes after the service is obtained.

I acknowledge that I have read and understand the information above. I understand I will be financially responsible for services that my insurance company indicates are "patient responsibility".

_____
Printed Name

✖ _____
Signature

_____
Date