EXHALE SINUS
TMJ | HEADACHE | SLEEP

814 E. Woodfield Rd.
Schaumburg, IL 60173
Tel: 773-234-5880
Fax: 708-273-5332

PATIENT REGISTRATION

CONSENT FOR MEDICAL CARE AND TREATMENT

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ AND FULLY UNDERSTAND ITS CONTENTS.

AUTHORIZATION FOR TREATMENT. I hereby voluntarily consent to such medical evaluation, treatment, services, and procedures as deemed necessary and appropriate for my condition based on the judgment of my doctor, his consultants, associates assistants, designee(s) and others in professional training programs ("health care providers").

NO GUARANTEE. I acknowledge that the practice of medicine is not an exact science and the health care providers have not made any guarantees or warranties as to the result of treatments or examination.

ILLINOIS INFECTIOUS DISEASE TESTING ACT. I understand and acknowledge that Illinois law provides if any health care worker is directly exposed to my blood or other bodily fluid, the healthcare provider(s) may perform tests on my blood or other bodily fluid to determine the presence of any communicable disease, including but not limited to, Hepatitis, HIV/AIDS and Syphilis. I understand that such testing is necessary to protect those who will be caring for me while I am a patient of Exhale Sinus and Facial Pain Center ("ESFPC").

NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of ESFPC's Notice of Privacy Practices, which provides detailed information about how ESFPC and others listed in the Notice may use and disclose my protected health information for the purposes of treatment, payment and health care operations.

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

RELEASE OF MEDICAL RECORDS. ESFPC or other healthcare providers who may treat me may use and disclose my health information for treatment, payment and health care operations without my specific authorization. ESFPC may share my medical information in any format it determines is appropriate to coordinate and seek payment for my care and to comply with public health reporting requirements. The information may be shared verbally, via fax, on paper, or through electronic health information exchanges.

SPECIFIC RELEASE FOR MENTAL HEALTH, SUBSTANCE ABUSE OR HIV INFORMATION. I specifically authorize ESFPC and its health care providers to release any and all information regarding mental health, substance abuse or HIV related diseases contained in my past or current record for the purposes stated in the above paragraph. I agree that the specific consent contained in this paragraph shall apply even if I am diagnosed and/or with one of the above conditions after I signed this consent.

FINANCIAL OBLIGATIONS

RESPONSIBILITY FOR PAYMENT. In consideration for services to be rendered, I agree to pay ESFPC for all services, facilities, and supplies provided to me at the established rates, including any deductible, co-payment, co-insurance or charges not covered by my insurance carrier or third party payers. I accept the responsibility for any costs, including attorney fees incurred in the collection of these charges. Furthermore, I acknowledge receipt of ESFPC's Insurance & Financial Responsibility Agreement.
INITIAL _____

I understand that if I do not consent to the release medical records to my insurance carrier or third-party payers, I am fully responsible for payment for all charges for treatment received, if such refusal results in the denial of payment. I certify that the information given by me for purposes of payment is, to the best of my knowledge, complete and accurate.
INITIAL _____

MEDICAID. ESFPC is a non-participating Medicaid provider. In the event I am a Medicaid patient, I fully understand that I am responsible for paying ESFPC for all services provided to me.

INSURANCE DISPUTES. If there is a dispute regarding the payment of my insurance or certain workers' compensation claim, I authorize ESFPC to bill me prior to the resolution of that dispute and I agree to pay those amounts.

COMMUNICATIONS

CONTACT AUTHORIZATION. I authorize ESFPC to contact me via telephone call, voicemail, email or SMS text messages to provide medical and/or financial information, including but not limited to, appointments, payment reminders, and delinquent notifications. I understand, and acknowledge, that my patient information may appear in the email or text. In order for ESFPC to collect any amounts I may owe, I expressly agree and consent that ESFPC or its designated collection agents may contact me by telephone at any telephone number I provide, or any telephone number that the collection agents obtain or, at any number forwarded or transferred from that number, regarding the services rendered, or any related financial obligations. Methods of contact may include pre-recorded/ artificial voice messages and/or use of an automatic dialing device, as applicable.

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I understand that if information is emailed to me, there may be some level of risk that this information could be read by an unauthorized party. By providing my e-mail address, I am accepting the risks and authorizing ESFPC and its health care providers to communicate with me electronically about my care, account, services, and/or education.

Email: _____

Home Number: _____ Cell Number: _____

Other: _____

I hereby give authorization to ESFPC and its health care providers to discuss my medical condition, including laboratory and diagnostic test results, and/or financial information with the following:

a. _____ (NAME) Relationship _____ Phone _____

b. _____ (NAME) Relationship _____ Phone _____

c. _____ (NAME) Relationship _____ Phone _____

PRESCRIPTIONS

ESFPC continues its position as the network exchange for the flow of vital patient information to physicians and other health care providers. It is essential to improve patient safety and the continuity of care with electronic connectivity between payers, physicians and pharmacists. ESFPC electronic health record (EHR) provides secure access for patients with commercial prescription coverage in the United States.

Prescription eligibility, benefit, formulary and medication history information is provided for consenting patients to authorized physicians at the point of care. Electronic prescriptions are delivered in real-time to pharmacists in the retail and mail order settings.

I consent to electronic prescriptions and acknowledge that ESFPC will use electronic connectivity between payers, physicians and pharmacists.

ACKNOWLEDGEMENT

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I UNDERSTAND THIS CONSENT MAY BE REVOKED IN WRITING BY ME AT ANY TIME, EXCEPT TO THE EXTENT ACTIONS WERE TAKEN PRIOR TO THE REVOCATION OF CONSENT.

_____ _____

Signature of Patient/Legally Authorized Representative Date

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INSURANCE & FINANCIAL RESPONSIBILITY AGREEMENT

Welcome to Exhale Sinus and Facial Pain Center ("ESFPC"). We believe you deserve the best care. That's why we strive to provide you with the best medical care possible to treat your personal situation. Each year, we provide medical care to hundreds of patients. Some of these patients have medical benefits while others do not. If you have medical benefits, congratulations! You are very fortunate. Below are some important things you should know. Please read this Agreement carefully, initial each section, and sign and date at the bottom.

INITIAL:

_____ Your medical benefits are based upon a contract made between you or your employer and an insurance company. If you have any questions regarding your medical benefits, please contact your employer or insurance company directly. Most medical benefit plans will never pay 100% of your medical care. It is only meant to assist you.

_____ We will bill your insurance as a courtesy. If insurance does not pay within 45 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between **YOU and your insurance company.** ESFPC is not, and cannot be, a part of that legal contract. Ultimately, you are responsible for all charges incurred by ESFPC. Any delinquency on your account will result in a $25 monthly late fee added to the account. In the event that we incur any expense in the collection of your account, expenses for collections agencies or court costs will be applied to your account.

_____ We currently accept all private pay, and most of the major commercial health insurance plans. This means that we work with many insurance companies. It is your responsibility to know if ESFPC is in-network and recognized by your insurance plan. Although we can maintain a computerized history of payments by a given company, they change; therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE.** If you would like to know your insurance benefit, we will be happy to file a "pre-authorization" with your insurance company prior to treatment. Keep in mind that this is still not a guarantee of coverage. A pre-authorization may delay treatment, but it will give you the best estimate of t your out-of- pocket expenses.

_____ It is **your responsibility** to know if your insurance has any deductibles, co-payments, age limits, exclusions, waiting periods, clauses or any other type of benefit limitation for the services received. Many times, these exclusions are provided to employees only and are not made available to our staff when confirming benefits. As a result, we can only estimate based on what your insurance discloses to us.

_____ We require payment in full for your estimated portion at the time of service. We accept all major credit cards, cash and checks. If your check payment has insufficient funds and is returned to us, there will be a $25 fee. Any discount you may have at the time of service will be revoked, and your future payment must be in cash, credit or debit card.

_____ A specific amount of time is reserved, especially for you, and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require **at least 24 hours notice** to avoid a $65 cancellation fee for an office visit and a $500 cancellation fee for procedures or surgery. **(Emergencies are an exception).**

ACKNOWLEDGEMENT

I ACKNOWLEDGE THAT I HAVE READ THIS AGREEMENT AND THE AGREEMENT HAS BEEN EXPLAINED TO ME. I FULLY UNDERSTAND ITS CONTENTS AND WAS GIVEN AMPLE OPPORTUNITY TO ASK ADDITIONAL QUESTIONS WHICH WERE ANSWERED TO MY SATISFACTION.

Signature of Patient/Legally Authorized Representative

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CHECK IN PROCESS:

1. Insurance card and a valid ID are required during the check in process for every visit.
2. A Patient/Parent/Guardian must notify the office of changes in address, telephone number or insurance.
3. You are required to pay your past due balance or balances.
4. You will be responsible for payment for charges of services rendered if we are unable to verify benefits.
5. We accept cash, checks, Visa, MasterCard, American Express, and Discover. (Payment is due at time of service.)
6. Insurance companies require a collection of your co-pay or contracted percentage of services at every visit. If you have a deductible that has not been met, you will be required to pay for the visit at the contractual rate. If your insurance does not pay for a service, the charges will be the responsibility of the Patient/Parent/Guardian. We recommend that you always question your insurance company regarding your benefits and do not assume that everything done in our office is covered by your insurance carrier.

APPOINTMENTS:

1. You must arrive 10-15 minutes prior to your appointment.
2. Rescheduling may be necessary if you are late for your appointment. We will try our best to work you in if time allows.
3. Appointment canceled with less than 24 hours in advance of your appointment will be billed with the following fees: $65.00 fee for a canceled office visit and $500 fee for a canceled procedure or surgery.

FINANCIAL RESPONSIBILITIES:

1. ALL DUE BALANCES MUST BE PAID PRIOR TO BEING SEEN, unless you have made a financial arrangement with our office (with the exception of emergency visits).
2. NO EXCEPTION for the following: Deductibles and Copay must be collected at the time of service.
3. Private Pay Patient appointments require a $100 deposit. This will be applied to your final bill. This is non-refundable if you cancel your appointment with less than 24 hours in advance.
4. There is a $25.00 fee for returned checks.

MEDICATION REFILLS:

1. Medication refills may be requested over the phone to treat stable, chronic medical conditions that require ongoing medication (i.e. allergies, rhinitis, etc.). Please note if you are out of refills, you may be due for a follow up appointment. Refills will not be provided after hours or on the weekends. Please allow 72 hours for these refills to be completed.
2. Antibiotics will not be prescribed over the phone. If you feel you may need an antibiotic, you will need to be seen.
3. Narcotics and controlled substances cannot be called in. Patient **MUST** see the Doctor for an appointment to discuss these medications.

OTHERS:

1. Medical records can be faxed to another physician free of charge for continuum of care and upon receipt of the medical records release.
2. Patients may obtain a copy of their medical record for a fee. Our office will provide patients their medical record in a form of an USB flash drive. Patients may also request paper copies; however, an additional fee may apply.
3. An excused absence for school or work will only be issued if you have been seen in the office for the illness. A note must be obtained at the time of visit.
4. Due to HIPAA laws, patients must check in with the receptionist and are not allowed in the back office without consent.
5. All telephone calls made to ESFPC for issues that normally necessitate an office visit, including but not limited to requesting medical advice or consultation, will be charged between $20 and $60 per call, depending on the length of the call. These calls may or may not be covered by your insurance and may result in additional payment due. You agree to pay all fees which are not covered by your insurance.

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