PARK PRIMARY CARE LTD. **EVERGREEN CARE CENTER LTD.**

PATIENT INFORMATION

Thank you for choosing our office. In order to serve you properly, we need the following information.
Please Print. All information will be confidential.

Date_____Patient Name_____Cell/HomePhone_____

SSN_____ ☐ Male ☐ Female Birth Date_____Email_____

Address_____City _____ State____ Zip_____

Check appropriate box: ☐ Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Single

Parent's name _____

Patient's or parent's employer_____Work Phone_____

PERSON TO CONTACT IN CASE OF EMERGENCY_____

PHONE_____**RELATIONSHIP**_____

RESPONSIBLE PARTY (Who is to receive the bills if other than self)

Person responsible for this account_____Relationship to Patient_____

Birth Date _____ Home Phone _____Cell Phone_____

Address _____ City_____ State_____Zip_____

Employer_____Work Phone _____

Please Initial:_____Full payment of balance is expected within 30 days of receiving your statement. Park Primary Care LTD, and Evergreen Care Center LTD are not responsible to mediate any legal agreements regarding financial responsibility.

INSURANCE INFORMATION

Name of insured_____Relationship to patient _____

Birth Date_____ SSN _____Name of employer_____

Work Phone_____

Do you have any additional insurance? ☐ Yes ☐ No if yes, please complete the following:

Name of insured_____Relationship to patient _____

Birth Date _____SSN _____ Name of employer_____

Work Phone _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable by me directly to the doctor.

X _____ _____

Signature of patient or parent of minor Date

PATIENT INFORMATION

COMMUNICATION METHODS

WE WILL USE THE MINIMUM LANGUAGE NECESSARY WHEN DISCLOSING YOUR DIAGNOSIS ON REFERRALS, LAB REQUESTS AND MAIL-IN PRESCRIPTIONS. WE MAY CONTACT YOU BY TELEPHONE FOR RESULTS, APPOINTMENT REMINDERS, OR PHYSICIAN QUESTIONS. IF WE LEAVE A MESSAGE IT WILL BE BRIEF, FOR EXAMPLE: "CALL YOUR DOCTOR'S OFFICE AT 708.423.6209."

PLEASE RELEASE INFORMATION ABOUT ME TO THE INDIVIDUALS I HAVE LISTED BELOW:

1._____ 2._____

3._____ 4._____

Notice of Privacy Practices – HIPAA

I HAVE READ AND RECEIVED THE NOTICE OF PRIVACY PRACTICES/ HIPAA NOTICE AND RULES

X_____ _____

SIGNATURE OF PATIENT **DATE** **PRINT NAME**

X_____ _____

SIGNATURE OF PARENT/LEGAL GUARDIAN **DATE** **PRINT NAME**

Financial Responsibility Statement
Consent for Treatment

Evergreen Care Center, Ltd **Park Primary Care, Ltd**

(Please Print) Patients Last Name)	Patients First Name	Middle Initial
(Please Print) Guarantor's Last Name	Guarantor's First Name	Middle Initial

Please check the appropriate description of your relationship to the patient

☐Self ☐ Parent/Legal Guardian of Minor ☐Other (Please Explain)

Assignment of Insurance Benefits: In consideration of the medical services rendered by Evergreen Care Center, Ltd and/or Park Primary Care, Ltd physicians, I hereby assign, transfer and give to Evergreen Care Center, Ltd and/or Park Primary Care , Ltd, all of my rights, title and interest to medical expense reimbursement benefits under any insurance policy, ERISA Plan, Medicare B benefits, or any other public or private healthcare benefit indemnification program or agreement otherwise payable to me for those services rendered by Evergreen Care Center, Ltd and/or Park Primary Care, Ltd. This agreement specifically includes, but in not limited to, an assignment of the rights to designate a beneficiary, add dependent eligibility, obtain payment of any auto or third party liability policy medical benefits due for this treatment and to have individual or group converted or continued in accordance with its terms and benefits. As a patient you may receive separate bills for services provided by outside laboratories that our providers utilize for further testing that is not provided at Evergreen Care Center, Ltd and/or Park Primary Care, Ltd. Any questions that you have about your insurance coverage or benefits should be directed to your health care plan and or certificate of coverage.

Guarantee of Payment: If my medical insurance coverage is not sufficient to satisfy the charges in full, I acknowledge that the resulting balance is not covered by the assignment and I will be fully responsible for the payment of the balance due upon discharge as consideration for medical services rendered. I agree to pay the established rates of Evergreen Care Center, Ltd and/or Park Primary Care, Ltd for all services, facilities, equipment and supplies rendered. I also authorize Evergreen Care Center, Ltd and/or Park Primary Care, Ltd, to procure a credit bureau report to facilitate collection of any self pay account balance and agree to pay the same. In the event that it should become necessary to resort to outside collection procedures, Evergreen Care Center, Ltd and/or Park Primary Care, Ltd, reserves the right to charge the patient the collection costs and reasonable attorney's fee.

The undersigned certifies that he/she has read and understands the foregoing, and is the patient or is duly authorized to accept the above terms on the patient's behalf.

Signature of patient/Personal Representative	**Date**
Printed name of Personal Representative	**If Personal Representative, indicate relationship**

Consent for Treatment: I wish to be treated and my permission is hereby given to Evergreen Care Center, Ltd and/or Park Primary Care, Ltd, its professional and clinical staff to administer any diagnostic or therapeutic treatment including the administration of any anesthetic as well as the performance of any procedure as may be deemed necessary or advisable in the treatment of myself or the minor child I am representing as a patient of Evergreen Care Center, Ltd and/or Park Primary Care, Ltd. I understand my physician will explain to me the nature of my condition, recommended treatment, and associated risk involved, and other ways this condition could be treated. No guarantees have been made to me about the outcome of this care.

Signature of patient/Personal Representative	**Date**
Printed name of Personal Representative	**If Personal Representative, indicate relationship**

Date: _____

Park Primary Care

Patient Name: _____ Age: _____ DOB: _____

Referring Doctor: _____ Occupation: _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

Children: Yes or No Married Single Divorced Widowed

List all ***allergies*** to medications and foods with reaction:

_____

_____

List all ***medications*** that you are currently taking. Please include all over the counter drugs.

Medication	Dosage	Medication	Dosage

List any prior ***surgery***, including dates:

_____

_____

_____

Past Medical History (Please circle all that apply)

Diabetes	Gout	Bleeding Disorders	Thyroid	Heart Disease
Ulcers	Asthma	High Blood Pressure	Hepatitis	Kidney Problems
HIV	Arthritis	Sickle Cell Disease	Stroke	Osteoporosis
Lung Disease	Mental Illness	Rheumatoid Arthritis	Tuberculosis	Phlebitis

Cancer: _____

Other: _____

Park Primary Care

Park Primary Care Patient Policy
Effective 1/1/13

Hours of Operation are:
Mon 9-630pm Tues 9-5pm Wed 9-5pm Thurs 9-2pm Friday 9-12pm
1st Saturday of Month 9-12pm

1. It is very important to keep your contact information up to date. If the doctor needs to contact you we must be sure that you can be reached. It is also important to have a second number to reach you or an emergency contact.

2. **DO NOT** page doctor or call service for medication refills.

3. Prescription refills need to be faxed from your pharmacy if possible.
   Our Fax # is 708-423-8152, please allow 48-72 hours.

4. When Referrals are requested, please allow 1-2 days for it to be put in the system and approval. If you go to a specialist without a referral you will need to reschedule your appointment. **Do Not** call day of appointment as referrals will not be issued same day.

5. Appointments that are not cancelled 24 hours before scheduled appointment time will be charged a $25.00 cancellation fee.

6. Missed appointments will be charged a $50.00 fee. Also, if you miss more then 3 appointments and are not seen by one of our primary care physicians within a 1 to 1 ½ years you will be discharged from our practice.

7. Co-Pays are due at time of service.

8. All account balances are expected to be kept up to date. Only 2 statements are sent, and when accounts are 60 days old, they automatically will be released to the collections agency along with a collection fee.

9. We expect our patients to be seen 2-3 times a year for chronic medication monitoring. Therefore, prescriptions will not be refilled longer than 6 months at a time.

Thank you for your cooperation and understanding.

_____ _____

Signature of Patient Date