



# ILLINOIS GASTROENTEROLOGY INSTITUTE

Illinois Medical Center  
1001 Main Street, Suite 500A  
Peoria, IL 61606

Ph: (309) 672-4980  
Fax: (309) 671-2930

Date: \_\_\_\_\_

Dear \_\_\_\_\_

Thank you for choosing **Illinois Gastroenterology Institute (IGI)**. Here is some information pertaining to your procedure.

### Location & Physician

Central Illinois Endoscopy Center    Proctor    Pekin    Methodist    OSF   with

Dr. \_\_\_\_\_

### Type, Date & Time

Upper Endoscopy (EGD)    Colonoscopy

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Please arrive at: \_\_\_\_\_

In addition, we have enclosed several forms. Please read each of them carefully and follow the instructions noted below.

- **PATIENT INFORMATION SHEET**
- **CONSENT FOR VERBAL RELEASE OF INFORMATION**
- **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**
- **PATIENT MEDICAL INFORMATION SHEET**
- **CURRENT MEDICATION LIST**
- **FINANCIAL POLICY AND PATIENT AGREEMENT**

Please fill out the above-mentioned forms **completely** and return in the enclosed envelope.

At some point before your procedure, a member of our scheduling team will call you to obtain any updates to both your medical and surgical history and your present medications. Our team member will also explain the procedure and provide you with preparation instructions.

### CANCELLATIONS

If you cannot keep your procedure appointment or should you need to reschedule, **PLEASE CALL OUR OFFICE AT LEAST 24-48 HOURS IN ADVANCE.** If you fail to arrive for your procedure twice without calling or should you cancel your procedure three (3) times consecutively, you may be terminated from our practice.

Thank you for choosing IGI.

Abdullah Al-Rashdan, M.D.  
Terry L Baldwin, M.D.  
Kenneth B. Camacho, M.D.  
Wasim Ellahi, M.D.

Noor A. Khaiser, M.D.  
Omar S. Khokhar, M.D.  
Eli Kuga, M.D., FRCP, FACP, FACG, AGAF  
Maureen A. Lillich, M.D., FACP

Donald E. Penn, Jr., M.D., FACP  
Michael R. Treanor, M.D., FACP, AGAF, FACG  
Scott Y. Wu, M.D., FACG, AGAF  
Brynn Cinnamon, MSN, APN, CNP  
Elly Fennell, APN, ACNS



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1001 Main Street, Suite 500A, Peoria, Illinois 61606, (309) 672-4980

## PATIENT INFORMATION SHEET

PATIENT LEGAL NAME \_\_\_\_\_ MAIDEN/AKA \_\_\_\_\_  
FIRST MIDDLE LAST  
MALE  FEMALE  BIRTHDATE \_\_\_\_\_ S. S. # \_\_\_\_\_ E-MAIL \_\_\_\_\_  
STREET \_\_\_\_\_ CITY / STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PRIMARY PHONE NUMBER \_\_\_\_\_ Is it OK to leave **messages** on your answering machine? YES  NO   
Is it OK to leave **test results** on your answering machine? YES  NO

ALTERNATE PHONE NUMBER \_\_\_\_\_ Is it OK to leave **messages** on your answering machine? YES  NO   
Is it OK to leave **test results** on your answering machine? YES  NO

EMPLOYER \_\_\_\_\_  
NAME ADDRESS CITY STATE ZIP

MARRIED/SPOUSE NAME \_\_\_\_\_

WERE YOU REFERRED BY A PHYSICIAN? YES  NO  IF YES \_\_\_\_\_ PHONE \_\_\_\_\_  
Name of physician

PRIMARY CARE PHYSICIAN \_\_\_\_\_

**PREFERRED/REQUIRED HOSPITAL** \_\_\_\_\_

EMERGENCY CONTACT PERSON \_\_\_\_\_  
NAME HOME PHONE NO. WORK PHONE NO.  
EMERGENCY CONTACT \_\_\_\_\_  
ADDRESS CITY, STATE ZIP CODE

**PRIMARY Insurance** \_\_\_\_\_  
Name

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_

Member Name \_\_\_\_\_

Member Soc. Sec. # \_\_\_\_\_

Member Date of Birth \_\_\_\_\_

Member I.D. \_\_\_\_\_

Relation to Insured \_\_\_\_\_

Group No. \_\_\_\_\_

**PRIMARY INSURANCE**  
**EMPLOYER NAME** \_\_\_\_\_

PUBLIC AID YES  NO

**SECONDARY Insurance** \_\_\_\_\_  
Name

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_

Member Name \_\_\_\_\_

Member Soc. Sec. # \_\_\_\_\_

Member Date of Birth \_\_\_\_\_

Member I.D. \_\_\_\_\_

Relation to Insured \_\_\_\_\_

Group No. \_\_\_\_\_

**SECONDARY INSURANCE**  
**EMPLOYER NAME** \_\_\_\_\_

RECIPIENT NO. \_\_\_\_\_

### **ASSIGNMENT OF BENEFITS / MEDICAL INFORMATION RELEASE**

I request that payment of authorized Medicare / Insurance benefits be made on my behalf to Illinois Gastroenterology Institute, for any services furnished to me. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to the above named doctor any information regarding my Medicare claims under Title XVIII of the Social Security Act. I hereby assign benefits to the doctor or group indicated on this claim.

Having insurance is not a substitute for payment. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original. This authorization is valid until it is revoked in writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

← PLEASE TURN OVER AND COMPLETE BACK OF FORM →

# ILLINOIS GASTROENTEROLOGY INSTITUTE

1001 Main Street, Suite 500A, Peoria, Illinois 61606, (309) 672-4980

## CONSENT FOR VERBAL RELEASE OF INFORMATION

Our policy at Illinois Gastroenterology Institute is to follow the legal aspect of patient confidentiality. Therefore, in order to discuss medical care, billing and treatment with anyone other than yourself either in the office or by telephone, we need your written consent.

Below please list those with whom we can discuss your medical care. Please list their name and relationship to you (i.e., spouse, child, parent, friend, etc.)

NAME:

RELATIONSHIP:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I hereby authorize Illinois Gastroenterology Institute to discuss my medical care with the above-listed person(s). This authorization is valid until it is revoked in writing.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

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## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

You will be given a copy of our Notice of Privacy Practices upon arrival for your appointment at our office. You will be asked to sign below to acknowledge that you were offered a copy of the notice. This authorization is valid until it is revoked in writing.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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### Office Use Only

\_\_\_\_\_ Patient refused to sign acknowledgment form.

\_\_\_\_\_  
Name and Title

\_\_\_\_\_  
Date

# ILLINOIS GASTROENTEROLOGY INSTITUTE

1001 Main Street Suite 500A Peoria, Illinois 61606 (309) 672-4980

## PATIENT MEDICAL INFORMATION SHEET

Name: _____ Birthdate: _____ Age: _____ Reason for Appointment: _____	Primary Care Physician: _____ Referred by: _____ Height: (in) _____ Weight: _____
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**Past Medical History (Check all that apply)**

<input type="checkbox"/> Acid Reflux <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Amyloidosis <input type="checkbox"/> Angina/Chest pain <input type="checkbox"/> Anemia <input type="checkbox"/> Anxiety <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Autoimmune disease <input type="checkbox"/> Back pain <input type="checkbox"/> Bipolar Disease <input type="checkbox"/> Blood clot <input type="checkbox"/> BPH 600 <input type="checkbox"/> Brain tumor <input type="checkbox"/> Cancer-Biliary <input type="checkbox"/> Cancer-Bladder <input type="checkbox"/> Cancer-Breast <input type="checkbox"/> Cancer-Cervical <input type="checkbox"/> Cancer-Colon <input type="checkbox"/> Cancer-Esophageal <input type="checkbox"/> Cancer-Kidney <input type="checkbox"/> Cancer-Leukemia <input type="checkbox"/> Cancer-Liver <input type="checkbox"/> Cancer-Lung <input type="checkbox"/> Cancer-Lymphoma	<input type="checkbox"/> Cancer-Ovarian <input type="checkbox"/> Cancer-Pancreas <input type="checkbox"/> Cancer-Prostate <input type="checkbox"/> Cancer-Skin <input type="checkbox"/> Cancer-Small Bowel <input type="checkbox"/> Cancer-Stomach <input type="checkbox"/> Cancer-Uterine <input type="checkbox"/> Cellulitis <input type="checkbox"/> COPD <input type="checkbox"/> Coronary artery disease <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> CVA/Stroke <input type="checkbox"/> Dementia <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes – Insulin <input type="checkbox"/> Diabetes – Noninsulin <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Duodenal ulcer <input type="checkbox"/> End stage kidney disease <input type="checkbox"/> Endocarditis Bacterial <input type="checkbox"/> Endometriosis <input type="checkbox"/> Eye disorders <input type="checkbox"/> Fibromyalgia/Polymyalgia	<input type="checkbox"/> Gallstones <input type="checkbox"/> Gastritis <input type="checkbox"/> Gastroparesis <input type="checkbox"/> GI Bleed Hx of <input type="checkbox"/> Glaucoma <input type="checkbox"/> Gout <input type="checkbox"/> Heart attack (MI) <input type="checkbox"/> Heart disease <input type="checkbox"/> Heart murmur <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV <input type="checkbox"/> Hypercholesterolemia <input type="checkbox"/> Hyperkalemia <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Hypertension <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hypokalemia <input type="checkbox"/> Hypotension <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Impotence <input type="checkbox"/> Irritable bowel syndrome <input type="checkbox"/> Liver disease <input type="checkbox"/> Lumbar disk disease	<input type="checkbox"/> Lupus <input type="checkbox"/> Lyme disease <input type="checkbox"/> Macular degeneration <input type="checkbox"/> Migraines <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Nephrolithiasis <input type="checkbox"/> Obesity <input type="checkbox"/> Osteopenia <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Peripheral neuropathy <input type="checkbox"/> Peptic ulcer disease <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Panic attacks <input type="checkbox"/> Pneumonia <input type="checkbox"/> Renal disease <input type="checkbox"/> Seizures <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Spinal stenosis <input type="checkbox"/> TIA <input type="checkbox"/> Ulcerative colitis <input type="checkbox"/> Vascular problems <input type="checkbox"/> Vertigo
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Other: \_\_\_\_\_

**Surgical History (Check all that apply)**

Problems with Anesthesia yes no    Problems with Adhesive Bandages yes no    Latex Allergies? yes no

<input type="checkbox"/> AAA repair <input type="checkbox"/> Adhesion Removal in Abdomen <input type="checkbox"/> AICD _____(type) <input type="checkbox"/> Aortic valve replace <input type="checkbox"/> Appendectomy <input type="checkbox"/> Arthroscopy <input type="checkbox"/> Artificial Heart Valve <input type="checkbox"/> Back Surgery <input type="checkbox"/> Breast biopsy	<input type="checkbox"/> CABG <input type="checkbox"/> Cesarean section <input type="checkbox"/> Carotid endarterectomy <input type="checkbox"/> Cataract surgery <input type="checkbox"/> Colon (bowel) resection <input type="checkbox"/> D&C <input type="checkbox"/> Fundoplication <input type="checkbox"/> Gastric bypass <input type="checkbox"/> Gallbladder removed	<input type="checkbox"/> Hernia repair <input type="checkbox"/> Hip replacement <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Implanted Defibrillator <input type="checkbox"/> Knee replacement <input type="checkbox"/> Lumpectomy <input type="checkbox"/> Lung Surgery <input type="checkbox"/> Mastectomy	<input type="checkbox"/> Mitral valve replace/repair <input type="checkbox"/> Orthopedic Surgery <input type="checkbox"/> Pacemaker <input type="checkbox"/> Prostate Surgery <input type="checkbox"/> Tonsillectomy/adenoidectomy <input type="checkbox"/> Tubal ligation <input type="checkbox"/> Vaginal delivery <input type="checkbox"/> Vasectomy
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Other: \_\_\_\_\_

← PLEASE TURN OVER AND COMPLETE BACK OF FORM →

Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_

**Family Medical History**

(Check Problem and who was diagnosed: Mother=**M**, Father=**F**, Sister=**S**, Brother=**B**, Grandmother=**GM**, Grandfather=**GF**)

<b>Problem</b>	<b>Who</b>	<b>Problem</b>	<b>Who</b>
<input type="checkbox"/> Alcohol liver disease	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF	<input type="checkbox"/> Cancer-Colon	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF
<input type="checkbox"/> Autoimmune disease	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF	<input type="checkbox"/> Cancer-Esophageal	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF
<input type="checkbox"/> Celiac disease	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF	<input type="checkbox"/> Cancer-Kidney	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF
<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF	<input type="checkbox"/> Cancer-Leukemia	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF
<input type="checkbox"/> GERD	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF	<input type="checkbox"/> Cancer-Liver	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF
<input type="checkbox"/> Hemochromatosis	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF	<input type="checkbox"/> Cancer-Lung	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF	<input type="checkbox"/> Cancer-Lymphoma	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF
<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF	<input type="checkbox"/> Cancer-Ovarian	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF
<input type="checkbox"/> Inflammatory Bowel Disease	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF	<input type="checkbox"/> Cancer-Pancreas	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF
<input type="checkbox"/> Precancerous colon polyp	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF	<input type="checkbox"/> Cancer-Prostate	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF
<input type="checkbox"/> Peptic Ulcer	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF	<input type="checkbox"/> Cancer-Skin	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF
<input type="checkbox"/> Cancer-Biliary	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF	<input type="checkbox"/> Cancer-Small Bowel	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF
<input type="checkbox"/> Cancer-Bladder	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF	<input type="checkbox"/> Cancer-Stomach	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF
<input type="checkbox"/> Cancer-Breast	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF	<input type="checkbox"/> Cancer-Uterine	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF
<input type="checkbox"/> Cancer-Cervical	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF	<input type="checkbox"/> Cancer-Other	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> B <input type="checkbox"/> GM <input type="checkbox"/> GF

Other: \_\_\_\_\_

**Medical and Social History:**

<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced Number of Children: _____ Occupation: _____		Pharmacy: _____ Address: _____	
Do you drink: <input type="checkbox"/> yes <input type="checkbox"/> no No. Drinks: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5+ Frequency: <input type="checkbox"/> day <input type="checkbox"/> week Do you smoke?: <input type="checkbox"/> yes <input type="checkbox"/> no Packs/day: <input type="checkbox"/> 1/4 <input type="checkbox"/> 1/2 <input type="checkbox"/> 1 <input type="checkbox"/> 1-3	Years smoked: _____ Previously smoked: <input type="checkbox"/> yes <input type="checkbox"/> no Length of time since quit: _____ Do you chew tobacco: <input type="checkbox"/> yes <input type="checkbox"/> no Drug use: <input type="checkbox"/> yes <input type="checkbox"/> no _____	Allergies: <input type="checkbox"/> yes <input type="checkbox"/> no _____ _____ _____	

# ILLINOIS GASTROENTEROLOGY INSTITUTE

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## CURRENT MEDICATION LIST

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  M /  F

**MEDICATIONS:** Please list all the medications/doses/frequency. This includes prescription, over-the-counter, aspirin, and arthritis medications. If you need additional space, please attach a piece of paper.

NAME OF MEDICATION	DOSAGE (mg)	FREQUENCY
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____
13. _____	_____	_____
14. _____	_____	_____
15. _____	_____	_____
16. _____	_____	_____
17. _____	_____	_____
18. _____	_____	_____
19. _____	_____	_____
20. _____	_____	_____
21. _____	_____	_____
22. _____	_____	_____

# ILLINOIS GASTROENTEROLOGY INSTITUTE

1001 Main Street Suite 500A Peoria, Illinois 61606 (309) 672-4980

## FINANCIAL POLICY AND PATIENT AGREEMENT

We are committed to giving you the best care possible. We expect in return that you have the same commitment to your medical and financial responsibility to us. The following is the financial policy for Illinois Gastroenterology Institute.

**CUSTOMER SERVICE:** If you wish to discuss your account and/or set up financial arrangements, please contact our billing department at (309) 672-4980 and carefully listen to the prompt. We accept cash, checks or credit cards (Visa and MasterCard) as payment. There will be a \$25.00 service charge on all returned checks.

**SELF-PAY PATIENTS (NO INSURANCE COVERAGE):** If you have an office visit, we require that you pay \$50 at the time of your office visit appointment. If you can pay for your **office visit in full** on the day of your appointment, you will receive a 15% discount.

**INSURANCE FILING:** As a courtesy to our patients, we will file your primary and supplemental insurance for you. However, you need to provide us with complete and accurate insurance information as well as a copy of your insurance card(s).

**HMO/PPO:** If we have an agreement with your insurance carrier, we will receive direct payment for covered services. Co-payments are due at the time of service. Deductibles and co-insurance amounts applied to the claim will be your responsibility. Services not covered or deemed not medically necessary by your plan will be billed to you and are your responsibility. If a referral is required, while we will assist you in getting the referral, you need to request it from your primary care physician and is your responsibility to obtain one. If a referral is not in place, you will be responsible for payment or your appointment may be rescheduled until a referral is received from your primary care physician. **It is your responsibility to inform us if you are having a procedure performed at any of the four hospitals and a pre-certification for that procedure is required.** Upon being contacted, we will then obtain pre-certification for that procedure on your behalf. If your insurance company does not pre-cert the procedure, you will be notified prior to the procedure being performed. **It is also your responsibility to inform our staff as to which hospital your insurance requires you to use.**

Please check one; OSF       METHODIST       PROCTOR       PEKIN

**INDEMNITY-TYPE INSURANCE:** Your insurance may or may not agree with the UCR (usual, customary and reasonable) charges for our local area. Your benefit plan may not cover all services or may even deny payment for services. You will be responsible for any remaining balance on your account once your insurance has processed our claim. **Once again it is also your responsibility to inform our staff as to which hospital your insurance requires you to use.**

Please check one; OSF       METHODIST       PROCTOR       PEKIN

**BILLING STATEMENTS:** Our statements are sent monthly. We allow 60 days for your insurance company to respond to our claim. If they have not responded in that time frame, we will send you a bill for the outstanding amount. We ask that you begin making payments on your account while you resolve any payment issues with your insurance company. We expect all charges to be paid within 60 days following submission of our first bill to you. Should you fail to pay within this time frame, we will enforce our right to engage a collection agency to recover the outstanding amount owed. In addition to the charge for our services, you will be required to pay the collection agency fees which are typically 33% to 50% of the amount owed.

**COPIES OF MEDICAL RECORDS:** We will be happy to copy your records for you. If you need copies you must first sign a medical records release form which we can mail to you for your signature. Fees for copying records are \$35.00 provided they are on site, should we need to retrieve your records from an archive, an additional \$10.00 will be applied.

### **ACKNOWLEDGEMENT**

By signing below, I am recognizing that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is my responsibility to pay any deductible, co-pay, or any other balance not paid for by my insurance company. This authorization is valid until it is revoked in writing.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date