REGISTRATION FOR NEW ELECTRONIC RECORDS

MICHIGAN AVENUE INTERNISTS

200 S. Michigan Ave, Suite 1400 Chicago, IL 60604
Office (312)922-3815 Fax (312)922-7449 Website www.MichiganAvenueInternists.com

Date ____________________ **(PLEASE PRINT)**

Name ____ SSN# _____-_____-_____
Last First Initial

Address ______________________________ City ____________ State ____ Zip Code ________

Telephone #s☎: Home ______________ Mobile ______________ Work ______________

Gender ☐ M ☐ F Age______ Birthdate__________ ☐Single ☐Married ☐Widowed **Email** ✉ ______________

Employer ______________________________ (New Patients) Referred by:______________________

Emergency Contact ____________________ Relation ________ Phone☎______________ ☐ Home ☐ Mobile ☐ Work

Your Cooperation with the Additional Information is Appreciated for National Research Purposes-PLEASE answer ALL Three (3)

Race ☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander ☐ Native Hawaiian ☐Black/African American
☐White ☐Hispanic ☐Other Race ☐ Decline

Ethnicity ☐ Hispanic ☐Non-Hispanic ☐Decline

Primary Language ☐ English ☐ Spanish ☐ French ☐ Greek ☐ Italian ☐Other __________
Please Specify

Please Specify Pharmacies as ALL RX Prescriptions are now Electronically prescribed

Local Pharmacy ______________________________ Phone ☎ ______________________

Address (or Cross Streets) ____
City State Zip Code

Mail Order Pharmacy (if applicable) ______________________ Phone ☎______________ State __________

Primary/Secondary Account Holder Information (If Not the Patient)

Responsible Party ____
Last First Initial

Relationship to Patient____________________________ Birthdate____________________________

Address ☐ Check if Address is Same (if not)______________________________________
& Street City State Zip Code

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________________
Name(s) of Insurance Provider(s)

and assign directly to Michigan Avenue Internists, LLC for all insurance benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________________ ______________________________ ______________
Responsible Party Signature Relation to Patient (if not self) Date

Michigan Avenue Internists, L.L.C.
200 S Michigan Avenue, Suite 1400 Chicago, IL 60604
312-922-3815(phone) 312-922-7449(fax) www.michiganavenueinternists.com

---

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices

I, ________________________, hereby give my consent to Michigan Avenue Internists, LLC to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of patient.

The patient acknowledges that this practice is using an electronic health record information system (the "**EHR System**"), in coordination with Northwestern Memorial Hospital. The collection and use of all information through the EHR System is primarily for the purpose of treatment of patients by NMH, this medical practice and other medical practices in a clinically integrated care setting. All information collected through the EHR System may also be shared with, and used by, NMH and certain other hospitals, academic institutions, and health care providers that perform medical or research activities on NMH's campus or otherwise in conjunction with NMH (including, but not limited to, Northwestern University, the Feinberg School of Medicine, Children's Memorial Hospital, and the Rehabilitation Institute of Chicago) for the following related activities, including without limitation: (a) conducting peer review; (b) promoting quality assurance; (c) mortality and morbidity analysis; (d) conducting utilization review; (e) evaluating and improving the quality of care; (f) promoting and maintaining professional standards; (g) examining costs and maintaining cost control; (h) conducting medical audits; (i) assisting the medical staff membership and credentialing process; (j) performing data quality management; (k) improving the efficiency and effectiveness of healthcare; (l) conducting research; (m) extracting data from the EHR System and any related database and incorporating it into a data warehouse maintained by NMH.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be made available to me at my next office appointment.

I acknowledge that the physician's Notice of Privacy Practices has been made available to me upon request at the front desk. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

Signed: ____ **Date**:_____________

If you are not the patient, please specify your relationship to the patient _____________

MICHIGAN AVENUE INTERNISTS, LLC PATIENT CONSENT FORM

- If we do not have confirmation of your insurance coverage either by a current insurance card or letter of eligibility from your insurance company or employer, you, the patient, are responsible for any charges incurred at the time of your visit. This remains in effect until such time as this information is received by this office.
- Many insurance companies do not cover preventative medicine or screening tests (i.e. physical examinations, cholesterol screenings) even though your physician may find it necessary. If this is the case and you agree to proceed with this test, you are responsible for payment.
- If your insurance company does not cover services deemed necessary by your physician and you agree to proceed with these services, you are responsible for payment.
- It is your responsibility to know what your insurance company will cover.
- It is your responsibility as the patient to know if your physician is "in-network."
- Michigan Avenue Internists requires that each patient presents his or her insurance card before ***every*** visit.
- Michigan Avenue Internists may assess a $25.00 fee for medical advice or treatment given over the phone or web portal. If you have any concerns with this policy, your physician would be happy to discuss this further.

I have read and understand the above statements and accept liability for all services rendered.

Patient Name (please print): ______________________________

Patient Signature: ______________________________

Date of Notice: ______________________________

Your Annual Wellness Visit – Summary of Services and Billing Practices

Patient Name: ________________________________ Date of Birth: ______________

An "Annual Wellness Visit" is a special, once-a-year visit with your doctor that specifically focuses on your long-term health. The purpose of the annual wellness visit is to identify potential health problems in the early stages when they may be easier and less costly to treat, and to have ample time to review and discuss your preventive care, independent of other more specific health concerns.

The visit is prevention-focused, not problem-focused, and may include the following:

- Review of past medical, surgical, social, and family history
- Examination and review of body systems
- Review of medications
- Review of immunizations
- Counseling/anticipatory guidance/risk factor reduction interventions
- Review of age/gender appropriate screening tests

If significant time is spent on new health concerns or unstable chronic conditions during this preventive visit, e.g. high blood pressure, diabetes, skin rashes, pain, depression, anxiety, or headaches, your doctor may bill a modest separate fee for this part of the visit, in addition to the usual preventive visit charge, to your insurance. This is considered an appropriate billing practice by major insurance companies.

While a purely preventive visit is often fully covered by health insurers once a year, a problem-based visit is not. Thus, any additional problem-based visit charges, or associated laboratory or testing charges, may be subject to your out-of-pocket payment responsibilities (e.g. co-pays, deductible or co-insurance) per the terms of your health plan.

I have read and understand the above policy. I acknowledge that I am responsible for any co-pay(s), deductible, co-insurance and/or non-covered service(s).

PATIENT SIGNATURE: __________________________________ DATE: ____________