Registration for MICHIGAN AVENUE INTERNISTS

200 S. Michigan Ave, Suite 805 Chicago, IL 60604
Office (312)922-3815 Fax (312)922-7449 Website www.MichiganAvenueInternists.com

Date ____________________ **(PLEASE PRINT)**

PATIENT INFORMATION

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

Ethnicity ☐ Hispanic / Latino ☐Non-Hispanic / Non-Latino ☐Decline

Primary Language ☐ English ☐ Spanish ☐ French ☐ Greek ☐ Italian ☐Other ____________________
(Please Specify)

PHARMACY INFORMATION

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 __________

INSURANCE INFORMATION

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

ASSIGNMENT AND RELEASE

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

PATIENT CONSENT FORM

Michigan Avenue Internists, L.L.C.

200 S. Michigan Ave, Suite 805 Chicago, IL 60604

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- 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 this information is received by this office.
- Many insurance companies do not cover preventive medicine or screening tests (i.e. physical examinations, cholesterol screening) 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 certain 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 require that each patient presents his or her current insurance card before *every* visit.
- Please note that effective April 1st 2009 Michigan Avenue Internists may assess a $25.00 fee for medical advice or treatment given over the phone. If you have any concerns 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 (print): ______________________________

Patient Signature: ______________________________

Date of Notice: ______________________________

CONSENT FOR RELEASE

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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: _____________________________